

Bristol City Council 'Health lens' Impact Assessment Form



These are Public Health views designed to inform decisions, not a full Health Impact Assessment (HIA). This means that the following document does not incorporate all the HIA principals, for instance the document does not incorporate the views of stakeholders (these will be gathered in the BCC public consultation), however it does include a consideration of the distribution of impacts and aim to reduce health inequalities, it considers impacts that are long term as well as short-term, and it considers the best available evidence and interprets it robustly. This document suggests mitigation to address the health impacts where this is possible.

Name of proposal	Bristol Community Links
Directorate and Service Area	People – Adult Social Care
Name of Lead Officer	Sonia Moore
Name of PH reviewer	Katie Currie and Lynn Stanley

Step 1: What is the proposal?

Please explain the proposal in Plain English, avoiding acronyms and jargon. This section should explain how the proposal will impact service users, staff and/or the wider community.

1.1 What is the proposal

To review options to co-design the service model for Bristol Community Links in order to reduce the core budget by £1.3m by April 2020 (split over 3 years).

Bristol Community Links services are provided for adults with learning difficulties and/or severe physical impairment and adults with dementia. Three hubs provide building-based facilities for people with complex and high level personal care needs. The hubs are a base for people to access community services and activities and provide space for people who need a safe, quiet environment.

Bristol Community Links services include:

- **Three Community Links centres**, based in North (Southmead/Henbury), South (Bishopsworth/Filwood) and Central (Lawrence Hill/Easton) Bristol, which provide services for people with complex and high level personal care needs.
- **Three drop-in centres** which offer low level support to people with learning disabilities who otherwise live independently in the community. These centres are located in community-based centres in and Lockleaze (North) Knowle and Easton
- **Transport to the community links centres.** People who attend the Community Links Centres are transported to and from the centres in minibuses.

This document will assess the health impact of the proposed changes on both service users and their carers.

1.2 What are the options being considered?

Following a comprehensive consultation with service users, carers, partners and providers, revised proposals are being considered as follows:

To deliver the vision and focus for the service, and ensure that the service operates within the reduced budget, it is proposed that the following activity will take place over the next 2 years:

- Transfer the provision of transport to and from the Links Centres to BCC Passenger Services from 1st April 2018
- Remove automatic entitlement to transport provision, on a case by case basis. Where there is appropriate transport available (either personal or public transport), it will be assumed that the service user will use this as a first option. People who receive higher rate mobility disability allowance will be expected to apply and use this as and when appropriate according to assessed needs.
- Undertake the relevant Management of Change processes to achieve efficiencies from the staffing budget, while maintaining service delivery for vulnerable adults. The detail is yet to be agreed and will be fully consulted on following a Cabinet Decision.

Extensive consultation and analysis has been conducted following the initial plans for Bristol Community Links (BCL). The recommendations are now that the drop in service will remain unchanged and, where possible be enhanced.

Step 2: What information do we have?

Decisions must be evidence-based, and involve people with protected characteristics that could be affected. Please use this section to demonstrate understanding of who could be affected by the proposal.

2.1 Policy context: What policies /strategies /NICE guidelines are relevant?

Bristol City Council strategies

The **17/18 business plan in the Corporate Strategy 2017-20** states a commitment to supporting carers by delivering the priorities in the Carers strategy. The carers strategy has four priorities which includes providing 'personalised breaks from caring' as an "essential part of making the caring relationship enjoyable, sustainable and ensuring the carer has an opportunity to have a life of their own" (Carers Strategy pg 22). The strategy also makes reference to the need to allow the carers to state the nature of the break, which might be one week a year, or a regular time each week.

The Adult Social, Care Strategic Plan 2016-2020 states that the vision for adult social care in Bristol is for people to get the right level and type of support, at the right time to help prevent, reduce or delay the need for ongoing support, and to maximise people's

independence. The focus will be on what we can do, what our partners and communities can do, and what individuals can do.

The Care Act

Under the Care Act, local authorities have to ensure that people who live in their areas receive services that prevent their care needs from becoming more serious, or delay the impact of their needs, can get the information and advice they need to make good decisions about care and support and have a range of provision of high quality, appropriate services to choose from. It states that local authorities need to work with their communities and provide or arrange services that help to keep people well and independent. Additionally The Act gives local authorities a responsibility to assess a carers needs for support, this might include providing care and support directly to the person that they care for, for example, by providing replacement care to allow the carer to take a break. It is possible to do this as long as the person needing care agrees.

Health and Social Care Act 2012

The Health and Social Care Act 2012 sets out local authorities' statutory responsibilities to take appropriate steps to improve the health of the people who live in their areas. The act requires local authorities to comply with National Institute for Health and Care Excellence (NICE) recommendations to fund treatments under their public health functions.

NICE Guidance

Older people with social care needs and multiple long-term conditions

NICE Guidance on older people with social care needs and multiple long-term conditions reiterates the obligations under the care act including helping carers to access support services and interventions, such as carer breaks¹.

Dementia

NICE guidance on supporting people with dementia says that health and social care services should aim to promote and maintain the independence and mobility of people with dementia. Important factors in services for people with dementia include: consistent and stable staffing, retaining a familiar environment, minimising relocations, physical exercise and participation in activities they enjoy. Lack of these factors and changes in these factors pose risks to health outcomes for people with dementia².

Learning Disabilities

NICE guidance on interventions for people with learning disabilities says that interventions and support should be provided: in the least restrictive setting; as close to their home as possible and in places where the person regularly spends time³.

2.2 What data or evidence is there which tells us who is, or could be affected?

Bristol Community Links are predominantly used by people with a learning disability and older people with dementia, so this means that both these groups could be impacted in some way. Additionally these services provide support to carers through the provision of

respite services, so they may also be impacted.

The Proposal's Equality Impact Assessment (EIA) and the consultation document include data about service users and how they might be impacted. However the EIA does not examine the impact of the proposals on carers, although carers were part of the consultation period and influenced the subsequent changes to the proposals.

The following provides evidence or data on the health impacts of those who may be affected by the proposed budget cuts, including both service users and carers.

Social Determinants of Health

The report 'Fair Society, Healthy Lives' 2010⁴ reviewed the evidence on the social determinants of health and recommended a fresh approach to reducing health inequalities. This report identified six key policy objectives to reduce health inequalities. Two policy objectives will most likely to be impacted by the proposal:

- Ensure healthy standards of living for all
- Strengthen the role and impact of ill-health prevention

2.2.1 Service Users

Bristol JSNA⁵, Public Health Outcomes Framework (PHOF)⁶ and other local evidence

Learning Disabilities

According to overall population estimates⁷, there are around 8,600 adults in Bristol with some level of Learning Disability in 2016. Of these, around 1,800 adults are estimated to have a moderate or severe learning disability, and hence likely to be in receipt of services. Nationally, the number of adults with a learning disability is expected to grow 10% by 2030⁸.

Dementia

It is estimated that there are around 4,100 people over 65 living with dementia⁹ in Bristol. 2,830 people in Bristol have a diagnosis of dementia recorded by their GP¹⁰. The number of people with dementia aged over 65 is projected to rise by 14% by 2024, and by 66% by 2039¹¹. The rate of emergency hospital admissions (per 100,000 population, aged 65+) for people with dementia is 3,813 in Bristol. This is significantly higher than the England average (PHOF).

Black, Asian and Minority Ethnic (BAME) population and dementia

A report commissioned by Bristol City Council into the dementia experiences of BAME people in Bristol¹² shows that:

- Whilst the number of white British people in the UK with dementia is expected to double by 2051, the numbers of people from BAME communities with dementia is expected to increase seven fold in the same time.
- People from BAME communities are more likely to experience a range of risk factors associated with dementia than their white British counterparts, including diabetes and cardiovascular disease.
- People from BAME population are reluctant to attend mainstream dementia services, preferring to use BAME led services

In Bristol, 16% of the population is from Black, Asian and Minority Ethnic (BAME) background (JSNA 2016). However it is not known what proportion of people with dementia are from the BAME community.

Social Isolation

People with learning disabilities and dementia are amongst the most socially excluded in society. In Bristol, 43.6% of adult social care users said they “have as much social contact as they would like” in 2015/16, similar to the England average (PHOF).

Review of National literature

Health of people with learning disabilities

People with learning disabilities experience health inequalities. They are more likely than the general population to: be obese or underweight; have diabetes; be on psychotropic medicine; have dental problems and have sight and hearing problems that may be undetected and untreated. They are less likely to do exercise¹³.

It is estimated that 1 in 5 people with learning disabilities will develop dementia and 1 in 50 people with Down’s Syndrome will develop dementia in their 30s¹⁴.

As well as having a poorer quality of life, people with learning disabilities die at a younger age than their non-disabled peers¹⁵. National research shows increased rates of health conditions for people with learning disabilities, including epilepsy, mental health and heart disease, and inequalities in life expectancy. Men with learning disabilities die an average 13 years sooner than the wider population whilst women die 20 years sooner¹⁶.

Health and wellbeing of people with dementia

Dementia and Alzheimer disease became the leading cause of death in England and Wales in 2015.¹⁷ 72% of people living with dementia also have another medical condition or disability¹⁸.

It is estimated that more than 20% of people with dementia have diagnosable depression at any one time, and many others have some depressive symptoms. It is distressing, reduces quality of life, exacerbates cognitive and functional impairment, and is associated with increased mortality and carer stress and depression¹⁹.

A quarter of hospital beds are occupied by people with dementia, who stay on average five days longer than people without dementia in a comparable situation²⁰.

Social isolation and mental health

A Mencap report says that 1 in 4 people with a learning disability spends less than 1 hour a day outside of their home due to cuts to day services (Mencap’s Stuck at Home report, 2012)²¹. Loneliness is a substantial problem amongst people with a learning disability. 50% of people with a learning disability experience chronic loneliness, compared to around 15-30% of people in the general population. Loneliness is linked to a number of health risks, such as depression, high blood pressure and higher mortality risk²². A 2007 study in the UK found that 54% of people with learning disabilities had a mental health problem²³.

A report published by Institute of Health Equity (2016)²⁴ says that:

- A third of people with dementia live alone and they are more likely to become socially isolated due to their symptoms and the lack of adequate care that would enable them to become more socially connected.
- Social isolation and loneliness are linked to dementia. Older people identified as being lonely are 1.63 times more likely to be diagnosed with clinical dementia than those who are not lonely.
- Social connectedness in mid and later life can ameliorate the symptoms and impact of dementia and can help to prevent more rapid deterioration.
- Mental stimulation in later life can protect and ameliorate against the symptoms of dementia and has the potential to delay or replace lost cognitive function by up to 1.75 years.
- Physical exercise and in mid and later life can ameliorate the symptoms and impact of dementia.

According to a YouGov poll of UK adults commissioned by Alzheimers Society in 2014 (2289 responses)²⁵:

- 44% of respondents feel part of their community
- 40% felt lonely recently
- 61% felt anxious or depressed

Peer support is advocated in national strategies and policy as an intervention to provide support in the community for people with dementia and their carers. Evidence shows that peer support can reduce the isolation and loneliness associated with dementia and provides support to help people live positively with dementia²⁶.

LGBT community and dementia

A recent report into dementia care for LGBT communities²⁷ says that LGBT people's experience of dementia support contrasts with that of their non-LGBT peers. Yet older LGBT people's relative isolation (they may be estranged from their families) increases their need for formal care services. Discrimination, prejudice and stigma associated with gender and sexual identity, can put them off using formal care and support services and exacerbate mental and physical health problems. Individuals are effectively subject to "triple stigmatisation" due to their sexual orientation or gender identity, their age, and their dementia²⁸.

It is estimated that there are 31,500 Lesbian, Gay and Bisexual people living in Bristol (JSNA). The proportion of people with dementia from the LGBT community is unknown.

2.2.2 Carers

Bristol JSNA²⁹, Public Health Outcomes Framework (PHOF)³⁰ and other local evidence

- There are over 40,100 carers in Bristol (all ages)³¹, which is just under 1 in 10 of the population (9.4%).
- Over the last decade (since 2001 Census) the number of unpaid carers recorded has increased by 5,000, but the proportion stayed the same (9.3% in 2001) as Bristol's population has risen considerably.
- The majority of adult carers (25,700) are caring under 20 hours a week but just over

9,000 are providing unpaid care for 50 hours or more each week (JSNA)

- The percentage of adult carers who have as much social contact as they would like according to the Personal Social Services Carers survey. In Bristol 33.3% of adult carers have as much social contact as they would like, which is significantly lower than 38.5% England (PHOF).

Review of National literature

Health of carers

Without proper support, carers are often pushed to breaking point and have to give up work, stop caring, or even go into hospital themselves³². The most recent GP patient survey found that 3 in 5 carers have a long term health condition, this compares with half of non-carers 6 out of 10 people (61%) said their physical health has worsened as a result of caring, while 7 out of 10 (70%) said they have suffered mental ill health³³.

Access to respite

A report written by the Princess Royal Trust for Carers found that more than a third of carers do not get any respite breaks away from their caring duties and that the pressures, concerns and responsibilities of caring result in at least a third of carers reporting that they have cancelled treatment or an operation for an existing health concern of their own³⁴.

Carers UK carries out an annual survey of carers to collect evidence on a whole range of issues affecting carers' lives. Respondents were asked what would make the most difference to improving their health and wellbeing. Regular breaks from caring was the most popular choice, with 42% placing access to breaks in their top three things. This was followed by good quality care services for the person they care for (35%)³⁵.

Social isolation and mental health

Care-givers are vulnerable to social isolation and loneliness. Loss of earnings and poverty, restrictions on leisure time, and the disability and symptoms of care recipients contribute to carers' social isolation and risk of depression, putting them at an increased risk of depression and dementia.³⁶

Studies, looking at the psychological risks associated with the role of care-givers, and particularly the role of care giving to a spouse with dementia, noted the decline in social interactions of carers. Care-givers experiencing social isolation have reduced opportunities for social interaction and intellectual stimulation³⁷. Depression and social isolation are two particular and common issues for carers, with at least eight out of 10 carers reporting feeling isolated and alone, which in turn leads to higher risk of MCI and dementia³⁸.

Ageing carers

One in six carers is an older person³⁹. Increasingly people with learning difficulties are living to a later age, which in turns means that their parent carers are older people, and this trend can be expected to continue⁴⁰. Inevitably the physical and emotional demands of family care become greater as the family carer ages. A research study of all older family carers found that this group was 'overwhelmingly exhausted and worried' and sacrificed their own mental and physical health and personal wellbeing to look after others. This group of family carers carry the heaviest caring responsibilities when measured both by the type of help

provided and the number of hours, the majority of older family carers spent over 60 h providing care despite their own very high levels of poor physical and mental health⁴¹. Nearly half of those supporting someone with a learning disability spent 100 h a week caring: 12% per cent higher than family carers of other groups⁴².

2.2.3 Transport

A local public health employee who works with people with learning disabilities commented that means testing for transport is a positive move. Many people with learning disabilities have bus passes and use public transport which contributes to independence. However, community transport services are not always easy for people with learning disabilities to use.

No research was found on the impact of means testing of transport on health.

2.3 Who is missing? Are there any gaps in the data?

- Data on the number of people from the BAME population with dementia or LD is not available. This makes it difficult to consider future needs of this population and the health impact of changes to services.
- Data on the number of people from the LGBT community with dementia in Bristol is not available. This makes it difficult to consider future needs of this population and the health impact of changes to services.
- There is no publicly available data on the demographics of those who have LD or dementia and are socially isolated. This data would help us understand what their needs are and how to engage them in activities and services that can have a positive impact on their health.
- Evidence of the effectiveness of services on the health and wellbeing of services for people with dementia and LD is limited. A rapid search of the evidence for effectiveness of community services for dementia patients revealed very little that was relevant or recent.
- According to a recent review of health and social care interventions which promote social participation for adults with LD⁴³ There is a significant gap in research evidence showing how health and social care workers can intervene to improve the social participation of adults with learning disabilities.
- Physical disability and sensory impairment - Information and data on people with physical disability and sensory impairment is not currently available and has been identified in the Bristol JSNA as a vulnerable group where data is needed in the future.
- People with learning disabilities are living longer. Active ageing should apply to all citizens. However, older people with learning disabilities are largely missing from broader health policy discussions of active ageing⁴⁴.
- The national dementia strategy does not include specific references to the LGBT community. There is relatively little research about the support needs of people living with dementia from LGBT communities⁴⁵.
- It is not clear whether we have information about the impact of the existing community links services e.g. how do the health outcomes of those with LD and

Dementia who use the Community Links Services compare with the health outcomes of those with LD and Dementia who don't use services? Is there evidence of delayed moves to residential care or reductions in need for health (e.g. GP visits, hospital admissions) or other social care services?

2.4 How have we involved, or will we involve, communities and groups that could be affected?

Significant consultation has been conducted both through open public consultation meeting and with service users and their carers⁴⁶.

Step 3: Who might the proposal impact?

Analysis of impacts on people must be based on likelihood.

Where evidence collected from multiple research methods converges, this adds extra strength to the evidence and the likelihood of impact. Definition of the likelihood of the impacts is described using the following qualitative terms. The likelihood of the impact is based on the assessed strength of evidence. For clarity throughout the impact analysis section, the potential impacts are in bold and the likelihood of an impact is underlined.

Definite = Will happen.

Overwhelming strong evidence from a range of data sources collected using various methods (level I).

Probable = Very likely to happen.

Direct strong evidence from a range of data sources collected using different methods (levels II/III).

Possible = More likely to happen than not.

Direct evidence but not from limited sources (level IV)

Speculative = May or may not happen.

No direct evidence to support (level V).

Please demonstrate your analysis of any impacts in this section.

3.1 Do the proposal and options have any potentially adverse health impacts bearing in mind inequalities?

Revisions made to the proposal are likely to have less detrimental health impacts than the original proposals:

- There is no published literature that provides evidence that the means testing of transport would have an impact on the health of service users.
- However, the implementation of means testing/ arranging transport could become a barrier to accessing services. If vulnerable users are no longer able to engage with

the service then this may have a detrimental impact on their, or their carers, health and wellbeing through increased social isolation, reduction in physical activity and reduction in mental stimulation and social contact.

The initial proposed changes to services are likely to have an impact on service users and their carers, including:

- Changes in day services to people with learning disabilities and dementia could lead to rises in emergency admissions and hospital stays and rises in admissions to residential care and inpatient units.
- Predicted increases in Dementia in the BAME population means that consideration should be given to partnership working in order to provide culturally appropriate services to cater for the growing need.
- A sustained focus on equality and rights for LGBT people with dementia is important. Funding cuts threaten to further marginalise communities which are already overlooked⁴⁷.
- People with learning disabilities are living longer. Consideration should be given to active ageing in this vulnerable group.

3.1.1 Will the proposal and options have a direct impact on health, mental health and wellbeing, health protection?

Health of service users

People with learning disabilities need mental stimulation and physical activity to ameliorate the symptoms and impact of their condition³². They also need to engage with others who understand their needs, to avoid social isolation which impact on health. If the community links services are redesigned, consideration should be given to how changes to services and possible transition to alternative services will impact on the health of service users.

Health of carers

Any changes to the provision of day services, which are used as respite for carers in turn risk impacting upon the health of carers. Carers are a group identified for influenza vaccination. Whilst the proposed changes do not directly impact on vaccination uptake there is a speculative risk that lack of respite care may impact the carers ability to keep their own medical appointments.

3.1.2 Will the policy have an impact on social, economic and environmental living conditions that would indirectly affect health?

3.1.2.1 Service users

Learning disabilities

Only 1 in 10 people with a learning disability are in paid employment, so they are generally

more financially vulnerable, less able to purchase services themselves and more reliant on those provided by social services⁴⁸. Any considerations in the proposal to introduce self-funding could make services out of reach for many of those in need of the service.

Dementia

The cost to the UK economy of services for people living with dementia is far higher than all other conditions combined, currently making up 66% of all mental health service costs and estimated to increase to 73% by 2026⁴⁹. The economic impacts of dementia are wide ranging and long lasting because of the characteristics of the conditions and the lack of early and effective interventions. They are associated with losing the ability to work (particularly in relation to early onset dementia or severe mental health problems) and increased utilization of health, social care and other support services. These factors impact on the individual, on their family and friends and on society.

A social return on investment (SROI) analysis into peer support for people with dementia

Social return on investment (SROI) is a practical tool that helps commissioners assess and value outcomes from an activity and focus on the impact of proposals and decisions, achieving value for money and considering wider costs and benefits.

According to a SROI report into peer support for people with dementia⁵⁰, the community support groups evaluated created positive social value for people with dementia, carers and volunteers. The SROI is expressed as a ratio of return and is derived from dividing the value of the impact by the value of the investment. The social value created ranged from £1.17 to £5.18 for every £1 invested (financial year 2014/15), dependent on the design and structure of the group. The shared outcomes across all three types of groups were: a reduction in isolation and loneliness; a feeling of stimulation (including memory) more than if remained at home, perhaps suggesting that different group structures can all lead to these outcomes.

The peer support groups reviewed provided facilitated environments for people to meet, socialise and engage in group activities. Three types of groups were examined: a community group/centre, local charity and a mainstream national charity. The groups differed in frequency, size, activities provided and ratio of volunteers to paid staff. Funding for the groups also differed including being locally commissioned, funded through charitable grants and through fundraising activities. The strength of the ratio varied between groups due to differences in group structure and outcomes produced.

BCC may find it helpful to consider the SROI for the different types of support for people with dementia when formulating its proposals.

3.1.2.2 Carers

Caring responsibilities impact on carers' income and resources: around 72% of carers have less income as a result of giving up work (one in five carers), reducing their working hours, or taking on more junior roles, resulting in the loss of pension contributions and subsequent loss of income in later life. Caring responsibilities can prevent people from dedicating time to leisure activities, engaging with part-time paid work and volunteering, and can incur costs such as buying in services, extra laundry, and heating the home for longer periods of time⁵¹. Lack of support and taking on sole responsibility for the care of another can result in carers

experiencing poverty and debt. Those caring for more than 20 hours a week are more likely to live in poverty than the general population, and this likelihood increases with the increasing number of hours of care provided⁵².

3.1.3 Will the proposal affect an individual's ability to improve their own health and wellbeing?

It is possible that changes to transport provision may have a positive impact on health and wellbeing of service users where empowering people to use alternative means of transport increases independence.

Day services provide social contact, mental and physical stimulation, maintain/restore independence and promote health and wellbeing. Changes in these services may impact on a service user's ability to improve their own health and wellbeing unless there are alternative ways for service users to gain/maintain the skills and knowledge required.

Changes to how support is provided is particularly challenging for people with learning disabilities and dementia, especially where they may have limited capacity to learn new skills and form new relationships.

People with learning disabilities and dementia are already vulnerable and can be progressively reliant on carers and services. The extension of independence resulting from day centre attendance can delay or prevent a move to residential care home⁵³.

3.1.4 Will there be a change in demand for or access to health and social care services?

Changes (reduction) in the day centre provision may increase the likelihood of need for more service users needing residential and acute care. Examples of need include:

- Service user's mental health declines due to lack of social interaction, leading to social isolation, anxiety and depression, lack of confidence and independence. This may lead to an increase in the need for mental health services and other health and social care services
- Service users physical health declines due to lack of exercise or activity provided by day centres, leading to loss of mobility and independence and deterioration of physical strength and physical health. This can lead to increased demand in health and social care services.

People with learning disabilities are living longer which means that they may need to use services for longer. Demand for services will also increase over time as the population and the need for services grows.

Dementia rates are set to rise as the population ages, particularly in the BAME group. This will lead to more demand and different demands for support for dementia patients eg BAME and LGBT population.

Ageing carers and increased demands on carers of people with learning difficulties and dementia will increase demands on health and social, as carers become unable to provide

care for others as their own health deteriorates.

Step 4. Identify the priority health impacts

4.1 Considering the answers to section 3 what are the priority health impacts taking into account the likelihood of them happening.

Response to the revised consultation regarding changes to transport provision:

- There is no published literature that provides evidence that means testing of transport would have an impact on the health of service users.
- Changes to transport provision may have a positive impact on health and wellbeing of service users where empowering people to use alternative means of transport increases independence.
- The implementation of means testing/arranging transport could become a barrier to accessing services.
- Where service users find using alternative means of transport challenging, they may withdraw from services which may have a detrimental impact on their health and wellbeing.
- Changes to transport provision may have a negative impact on the health and resilience of carers where their opportunity for respite is negatively impacted. Where carers themselves become involved in organising/provision transport for the service user, or supporting the service user to use alternative means of transport, this may have a negative impact on the mental health of a carer eg stress and anxiety.

Response to the initial consultation

- Social isolation as a risk factor for deterioration in health in people with learning disabilities and dementia.
- Deterioration in mental health due to lack of stimulation and psychological support for people with learning disabilities and dementia.
- Ageing population - growing rates of dementia in general population but also in groups where services are not designed to meet their needs eg BAME, LGBT.
- Increased pressure on carers reducing their health, wellbeing and resilience.
- Carers feeling unable to continue in their caring role which could lead to breakdowns in care, increased need for social care involvement and residential placements.

4.2 Can these impacts be mitigated or justified? If so, how?

The revised proposals regarding changes to transport provision mitigates against detrimental impact on service users by conducting an individual review of needs with each services user before any changes are made.

In addition, it is recommended that the impact of proposed changes is reviewed on an ongoing basis in order to monitor that any changes do not result in detrimental impact on service users and carers, unanticipated negative effects on other parts of the health and social care system or increased inequalities in health.

The needs of the carer should be considered at the same time as the service user when assessing transport needs to avoid unnecessary impact on carer health.

Step 5.

Stakeholder views - if you have any before the public consultation. If views are being gathered via the public consultation ensure these are collected as health views in the BCC final analysis.

A thorough public consultation process has been followed.

Step 6. Does the proposal create any health benefits?

6. 1 Considering the answers to section 3 what are the priority beneficial health impacts taking into account the likelihood of them happening.

The revised proposal to makes changes to transport provision is less likely than the original proposals to have a detrimental impact on the health of service users and carers.

In addition, it is possible that the originally proposed service redesign could enable:

- Partnership work in supporting BAME led dementia support as per recommendation of BAME dementia report.
- Developing new models for supporting ageing LGBT community (at risk of developing dementia) through partnership working.

6.2 Can they be maximised? If so, how?

Opportunity to develop new ways of working, form new partnerships (e.g. BAME and LGBT communities). The FITS⁵⁴ model which develop the expertise of care home staff to better support people with dementia might provide a model that could be adapted for use in day centres and drop-ins. This might allow a more diverse range of providers to be used across the City.

Step 7. Conclusion and recommendations

The revised proposals are likely to have less of an impact on health than the initial proposals. However the following should be considered:

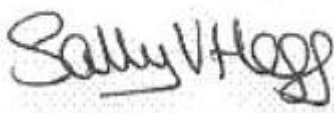
- Changes to transport provision may have a positive impact on health and wellbeing of service users where empowering people to use alternative means of transport increases independence.
- Where service users find using alternative means of transport challenging, they may withdraw from services which may in turn impact on their health and wellbeing.
- Changes to transport provision may have a negative impact on the health and resilience of carers where their opportunity for respite is negatively impacted.
- It is recommended that the impact of proposed changes is reviewed on an ongoing

basis in order to monitor that any changes do not result in detrimental impact on service users and carers, unanticipated negative effects on other parts of the health and social care system or increased inequalities in health.

The following should be considered in relation to the original proposed changes:

- Reduced services may result in
 - Social isolation which is a risk factor for deterioration in health in people with learning disabilities and dementia.
 - Deterioration in mental health due to lack of stimulation and psychological support for people with learning disabilities and dementia.
 - Increased pressure on carers reducing their health, wellbeing and resilience.
 - Carers feeling unable to continue in their caring role which could lead to breakdowns in care, increased need for social care involvement and residential placements.
- Growing rates of dementia in general population, but also in groups such as BAME and LGBT whose needs, according to the evidence, are not always met by services.
- People with learning disabilities are living longer.

Sign off by DPH (Acting)

Service Director sign-off 	Officer sign-off Katie Currie Lynn Stanley
Date 6.11.17	Date 1/11/2017

Appendix 1.

<p>Stage 2. Identify Health Impacts</p>	<p>Answering yes to these questions indicates that this is an important health impact. Be explicit and jot down what expert advice or literature you have used to make your judgement</p>					<p>Stage 3: Prioritise health impacts</p>
<p>Describe the health impacts</p>	<p>Will the health impacts affect the whole population or will there be differential impacts within the population? You should consider whether any inequalities groups* will be particularly affected.</p>	<p>Will the health impacts be difficult to remedy or have an irreversible impact?</p>	<p>Will the health impacts be medium to long term?</p>	<p>Are the health impacts likely to generate public concern?</p>	<p>Are the health impacts likely to generate cumulative and/or synergistic impacts?</p>	<p>Combining the answers, on balance will the health impacts have an important positive or negative impact on health? Provide a brief overview of the reason for your decision on prioritization.</p>
<p>Impact of transitions/ changes to care on service users</p>	<p>Service users with learning disabilities and dementia are vulnerable groups who are already affected by health inequalities. An ageing population and increases in rates</p>	<p>It depends on whether there are alternatives to current services and how this might mitigate the risk of impact on health.</p>	<p>It depends on whether there are alternatives to current services and how this might mitigate the risk of impact on health.</p>	<p>Yes – cuts to social care services is a very emotive topic.</p>	<p>Changes to day services will likely impact on service user’s mental and physical health. This in turn will put pressure on other parts of the health and social care system.</p>	<p>There is a strong risk that changes to this service could have an impact on the health of current service users and increase the demand on other parts of the health and social</p>

	<p>of dementia will increase demand for services. There are significantly higher increases expected in rates of dementia in BAME population. LGBT population is ageing and at risk of dementia. Services need to adapt to cater for their needs.</p>					<p>care system. Consideration needs to be given to future service users and how cuts will impact on a growing and changing need.</p>
<p>Impact of transitions/ changes to care on carers</p>	<p>This is already a group with protected characteristics</p>	<p>Not necessarily</p>	<p>Possibly</p>	<p>Yes</p>	<p>The health and care system is increasingly relying on the contribution of carers. Ongoing cuts to health and social care risk more pressure and less support for carers.</p>	<p>There is a strong risk that changes to this service could have an impact on the health of carers.</p>
<p>Means testing for transport and impact on health and poverty</p>	<p>Some people with learning disabilities have bus passes and</p>	<p>It depends on detail of proposals. It may be possible to</p>	<p>Social isolation disproportionately affects people with learning</p>	<p>yes</p>	<p>Possibly, due to the cumulative effects of health impacts and</p>	<p>If means testing for transport if well thought through this could</p>

	<p>have access to Bus Buddies scheme, which helps to increase independence. Some service users have limited capacity to work and are already living in poverty. They may also lack the capacity or ability to use other forms of transport. These factors may lead to withdrawal from services which may have a detrimental impact on health, both physical and mental.</p>	<p>mitigate the risks through learning from other parts of the country who have made similar changes.</p>	<p>disabilities and dementia. Changes to transport provision could pose the risk of withdrawal from support services in the short term but withdrawal from society as a whole which can make this group more vulnerable in the longer term.</p>		<p>deterioration.</p>	<p>mitigate any risks to impact on health.</p>
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¹ Older people with social care needs and multiple long-term conditions (NG22) 2015

² NICE (2016), CG42: Dementia: supporting people with dementia and their carers in health and social care

³ NICE (2015), NG11: Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges

⁴ Marmot M (2010), Fair Society, healthy lives: The Marmot Review: strategic review of health inequalities in England post 2010

⁵ Bristol JSNA 2016

⁶ Public Health England, Public Health Outcomes Framework available at <http://www.phoutcomes.info/public-health-outcomes-framework>

⁷ Institute of Public Care, POPPI and PANSI tools, www.poppi.org.uk ; national 2004 prevalence estimate applied to the Bristol population; accessed Oct 2016

⁸ Projecting Adult Needs and Service Information, 'Learning Disability Estimates'

⁹ Source: Estimated dementia prevalence (65+), NHS England, July 2016: www.england.nhs.uk/mentalhealth/dementia/monthly-workbook/

¹⁰ QOF 2014-15, via Public Health Dementia Profile: <http://fingertips.phe.org.uk/profile-group/mental-health/profile/dementia>

¹¹ Prevalence rates from "Dementia UK: report into the prevalence and cost of dementia" (Alzheimer's Society, 2007) applied to ONS population projections. Supplied by Bristol City Council's Performance, Information and Intelligence service

¹² The Bristol BME People Dementia Research Group (2017), Dementia Experiences of People from Caribbean, Chinese and South Asian Communities in Bristol

¹³ National Development team for inclusion (2017), Better health for people with learning disabilities

¹⁴ Alzheimer's Society. (2015). Learning disabilities and dementia factsheet. http://www.alzheimers.org.uk/site/scripts/download_info.php?fileID=1763

¹⁵ Statement from Public Health England Learning Disability Profiles

¹⁶ "Confidential Inquiry into premature deaths of people with learning disabilities"; University of Bristol, 2013; www.bristol.ac.uk/cipold

¹⁷ ONS (2016), Deaths registered in England and Wales (Series DR): 2015.

<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsregisteredinenglandandwalesseriesdr/2015#dementia-and-alzheimer-disease-was-the-leading-cause-of-death-in-2015>

¹⁸ Dowrick, A. Southern, A (2014) Dementia 2014: Opportunity for change by the Alzheimer's Society

¹⁹ Livingston G et al (2017), Dementia prevention, intervention and care

²⁰ Lakey, L (2009) Counting the cost: Caring for people with dementia on hospital wards published by the Alzheimer's Society

²¹ Mencap (2012) Stuck at home: the impact of day service cuts on people with a learning disability available at www.mencap.org.uk

²² Gilmore L and Cuskelly M (2014) , Vulnerability to loneliness in people with intellectual disability; An explanatory model

²³ Cooper SA, Smiley E, Morrison J, Williamson A and Allan L (2007). Mental ill-health in adults with intellectual disabilities: prevalence and associated factors. British Journal of Psychiatry, 190, pp. 27-35.

²⁴ Institute of Health Equity (2016), Inequalities in Mental Health, Cognitive Impairment and Dementia among older people

²⁵ Alzheimer's Society (2014), Dementia 2014: Opportunity for change

²⁶ Keyes, S. E., et al. (2014). "We're all thrown in the same boat ..." A qualitative analysis of peer support in dementia care. Dementia: April 2014; Department of Health 'Healthbridge Report ' evaluating peer support networks and role of dementia advisers; Dementia Action Alliance and Faculty of Psychologists Report into Post-diagnostic support for people living with dementia; Joseph Rowntree Foundation 'A stronger collective voice for people with dementia'

²⁷ ²⁷ National Care Forum (2017) Foundations for the future: dementia care for LGBT communities

²⁸ Dementia Action Alliance briefing http://www.dementiaaction.org.uk/news/19643_dementia_and_the_lesbian_gay_bisexual_and_trans_lgbt_population

²⁹ Bristol JSNA 2016

³⁰ Public Health England, Public Health Outcomes Framework available at <http://www.phoutcomes.info/public-health-outcomes-framework>

³¹ 2011 Census,

³² State of Caring, 2017

³³ GP patient survey 2016)

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- ³⁴ BMJ, *Health of young and elderly informal carers: analysis of UK census data*. BMJ 2003; 327–1388 2003.
- ³⁵ Carers UK (2017), *The State of Caring*. London
- ³⁶ Institute of Health Equity (2016), *Inequalities in Mental Health, Cognitive Impairment and Dementia among older people*
- ³⁷ Vitaliano, P., et al., Does caring for a spouse with dementia promote cognitive decline? A hypothesis and proposed mechanisms. *The American Geriatrics Society*, 2011. 59(5): p. 900-8.
- ³⁸ Princess Royal Trust for Carers (2011) *Always on call, always concerned: a survey of the experiences of older carers*. London, Princess Royal Trust for Carers.
- ³⁹ The Audit Commission, *Support for carers of older people, Independence and well-being 5*. 2004: London.
- ⁴⁰ Carol Walker (2015) *AGING AND PEOPLE WITH LEARNING DISABILITIES* Ageing and people with learning disabilities: in search of evidence
- ⁴¹ The Princess Royal Trust for Carers, *Always on call, always concerned. A survey of the experiences of older carers*. 2011.
- ⁴² NHS Information Centre (2010) *Survey of Carers in Households –England 2009-10*. Available at: <http://www.ic.nhs.uk/pubs/carersurvey0910>
- ⁴³ Howarth S et al, 2016, *Health and Social Care Interventions which promote social participation for adults with learning disabilities: a review*. British Journal of Learning Disabilities.
- ⁴⁴ Foster L, Boxall K (2015) *People with learning disabilities and ‘active ageing’*; Social Care Online
- ⁴⁵ National Care Forum (2017) *Foundations for the future: dementia care for LGBT communities*
- ⁴⁶ Bristol City Council (2017) *Equality Impact Assessment, Bristol Community Links and Adult Drop Ins*
- ⁴⁷ *Implications of reductions to public spending on LGB&T people and services*, NatCen Social Research, Nov 2016 <http://natcen.ac.uk/our-research/research/implications-of-reductions-to-public-spending-on-lgbt-people-and-services/>
- ⁴⁸ Mencap (2012) *Stuck at home: the impact of day service cuts on people with a learning disability* available at www.mencap.org.uk
- ⁴⁹ Kings Fund (2008). *Paying the Price*. London: Kings Fund
- ⁵⁰ Health Innovation Network South London (2015), *Peer support for people with dementia. A social return on investment (SROI) study*
- ⁵¹ Travers, A.F., *Caring for older people. Carers*. BMJ, 1996. 313(7055): p. 482-6.
- ⁵² *Inequalities in Mental Health, Cognitive Impairment and Dementia Among Older People*.
- ⁵³ Age UK (2011) *Effectiveness of day services, summary of research evidence*
- ⁵⁴ https://www.worcester.ac.uk/documents/Aging_and_Mental_Health_Journal_Article_13_Jul_2015.pdf