Equality and Safety Impact Assessment

The **public sector Equality Duty** (Section 149 of the Equality Act) requires public bodies to have due regard to the need to eliminate discrimination, advance equality of opportunity, and foster good relations between different people carrying out their activities.

The Equality Duty supports good decision making – it encourages public bodies to be more efficient and effective by understanding how different people will be affected by their activities, so that their policies and services are appropriate and accessible to all and meet different people's needs. The Council's Equality and Safety Impact Assessment (ESIA) includes an assessment of the community safety impact assessment to comply with section 17 of the Crime and Disorder Act and will enable the council to better understand the potential impact of the budget proposals and consider mitigating action.

Name or Brief Description of Proposal	This document concerns a proposed Integrated Intermediate Care and Hospital Discharge to Assess (D2A) Model for Southampton that meets the national Hospital Discharge Operational Model requirements as per current government guidance most recently updated 5th July 2021. It highlights the current position, illustrating some of the challenges, with a particular focus on the requirement to move from an over dependency on nursing/residential care home beds to discharging more patients home in line with "Home First" principles.
Brief Service Profile (including number of customers)	A primary government assumption at the outset of the COVID-19 crisis was that acute hospital beds would be in high demand and thus the optimisation of flow out of the hospital would be a priority. In March 2020 as part of the Government's response to COVID, legislation was introduced with immediate effect that changed the timescales and approaches associated with hospital discharge focussing on a "Home First Discharge to Assess (D2A) Operational Model". These changes have undergone further adaptation since their initial implementation and are now the expected ongoing Hospital Discharge and Community Support model as set out in the Government's Policy and Operating model published on 5 July 2021. The key features of the Hospital Discharge Operational Model are:- • An Expected Discharge Date should be established at the earliest point possible in a patient's journey to allow for pre-emptive planning and information sharing to take place. • A "Criteria to Reside" has been developed which describes the clinical scenarios in which a patient would require acute inpatient care. If the patient doesn't clinically meet these scenarios when assessed then the expectation is that they should be discharged from the bed on the same day. • Once a patient is ready for discharge they should be discharged

as soon as possible on the same day.

- A patient's home ("Home First") will be the default discharge destination even if intensive support or 24 hour care is required to achieve this.
- "Discharge to Assess" should be the default approach which requires that functional assessment of need and long term care requirements should take place in the community not in a hospital setting.

The Guidance identifies 4 Hospital Discharge Pathways which include expected demand on each:-

Discharge to Assess model – pathways[2]:

- Pathway 0: 50% of people – simple discharge, no formal input from health or social care needed once home.
- Pathway 1: 45% of people – support to recover at home; able to return home with support from health and/or social care.
- Pathway 2: 4% of people – rehabilitation or short-term care in a 24-hour bed-based setting.
- Pathway 3: 1% of people – require ongoing 24-hour nursing care, often in a bedded setting. Long-term care is likely to be required for these individuals.

The expectation is that all patients, regardless of their final eligibility for funding, will follow this process and so the community health and social care system is now managing the assessment and care of self-funders in the same way as all other patients/clients from an earlier stage up to the point that their needs and eligibility for support is confirmed.

On average there are 2733 patients discharged from hospital on a monthly basis (based on May/June 2021 data). The Southampton position when aligned with national expectations is:-

- Pathway 0 – 73% (national expectation 50%)
- Pathway 1 – 16% (national expectation 45%)
- Pathway 2 – 7% (national expectation 4%)
- Pathway 3 – 4% (national expectation 1%)

This particularly demonstrates that we need to shift towards supporting more people to return home within the current discharge guidelines undertaking more homebased (D2A) assessments for onward care.

The proposal seeks to increase our community resources associated with our hospital discharge hub, (Single Point of Access (SPOA)) homecare, reablement and therapies to give the opportunity of greater

	support at home whilst simultaneous reducing our bed capacity to shift resources from one provision into another. This will also be supported through national funding designed to support hospital avoidance and discharge.
• **Summary of Impact and Issues**	The new model outlined in the proposal will improve outcomes for both patients and the system as a whole by addressing the following issues:- • Poor or un-timely discharge planning – meaning that patient needs are not always known soon enough, information is poor, thus driving more risk adverse discharge planning. Estimated dates of discharge (EDDs) are not routinely established or communicated and twice daily ward rounds/reviews are not in place on all wards. The lack of pre-discharge planning also means that patients with particular needs e.g. mental health problems, learning disabilities, homeless potentially may not be flagged as needing extra support until the point that they are due to be discharged. • Again linked to the above point when patients remain in hospital longer than is required they risk hospital acquired infection and also deconditioning which makes recovery more difficult. • D2A capacity is heavily focussed on beds – whilst this was partly due to the need to step up a lot of capacity quickly to respond to the new guidance which came out in March 2020 and demanded immediate action, it has meant that the default position has been to discharge patients with more complex needs to a bedded environment as opposed to exploring alternative options. The majority of patients that access a D2A bed stay in residential/nursing home care following their ongoing needs assessment. There could be a range of reasons for this, including that people tend to decondition whilst in a residential/nursing home environment or they get used to the residential/nursing home environment and do not want to leave (in many circumstances people have moved to non D2A beds in the same nursing homes). The primary concern is that people who may, at the point of hospital discharge, have been able to return home with the opportunity to regain independence may not have the chance to do so. • The current Single Point of Access (SPOA) model is only resourced to provide a reactive response –to onward care referrals. The SPOA is currently not constructed in a way that would enable it to call upon wider expertise quickly in a more proactive response to referrals or “pull” patients from hospital; although some resources are aligned with the SPOA others are not so easily accessible e.g. housing, mental health and homelessness support). There is a need to strengthen links with therapy, Mental Health, Continuing Health Care, Housing and Homelessness services, Voluntary Orgs, and Brokerage to ensure that support is proactive and timely particularly for those

	individuals with increased complexity. • Insufficient capacity in the community to provide the level of support and immediacy of response required to support a more Home First model. Currently the Urgent Response Service, Community Independence Teams, End of Life outreach services and the homecare framework are already challenged in meeting the current demand and would need increased resourcing to meet the demands of this model. 24/7 medical cover also isn't available currently. The outcome is again that patients that may have been able to return home and, in some cases regain their independence, have less opportunity to do so due to the availability of resources. In summary the current system isn't proactive and timely, doesn't consistently support people to be on the discharge pathway that they should be, doesn't uniformly support people with particularly complex needs and can be resource driven rather than person centred.
Potential Positive Impacts	The focus of the hospital discharge model is primarily to ensure that people are only in hospital for as long as is absolutely necessary and that when they are discharged every possible effort is made to get them back to their own home environment. The benefits being:- • People who remain in hospital are at increased risk of contracting a hospital acquired infection it is therefore important that they only remain in hospital for as long as is necessary. This proposal seeks to ensure that people are discharged as soon as they are clinically able to do so reducing these risks. • People who are in bed based care be it hospital, residential or nursing home are at increased risk of deconditioning as they are more likely to be sedentary, less confident or aware of their environment, and more likely to be "cared for" and thus likely to do things for themselves. The proposal aims to get people home to an environment that they know and feel comfortable in and then, where possible, seeks to provide the care and therapy required to actively promote optimum levels of independence. • Ensuring that we have multi-disciplinary integrated systems that support people to be on the correct hospital discharge pathway, such as the SPOA, is important as this reduces the risk that people who can be at home with a level of independence will be able to do so. • People with limited or no capacity and/or communication issues, such as those with learning disabilities, mental health needs or autism are better served through earlier involvement from the community so that the appropriate communication and advocacy support can be put in place to support the discharge and ongoing planning. • People with mental health needs such as dementia, learning disabilities for example autism are more likely to function better if their environment, routines and networks are maintained therefore getting people home as priority to support ongoing

	assessment can help decrease ongoing uncertainty and anxiety. • Symptoms can be exacerbated for people with dementia if they are in an environment that is unknown to them therefore getting people out of hospital back to a “home” environment for ongoing assessment can reduce the level of confusion and associated anxiety. • Having a fully functioning SPOA will also increase the opportunity for people with particularly complex needs or lives (e.g. people with LD, MH needs etc) are supported in the hospital discharge process at an early stage maximising their opportunities to return to an optimal level of independence within the community. • For those people that are at the end of their life the proposal would again seek to get people home to die in an environment that they recognise and feel comfortable in and where possible with their belongings and family around them. • Assessing long term care needs in the environment that people live, unlike a hospital setting, is likely to improve the accuracy of those assessments as individuals respond differently in their own homes and the assessors can gauge their needs in a more realistic context. • Homeless people, particularly those discharging to the street, may require planning that involves developing or established community networks. The early planning will support this and will also help to identify those people who require safe appropriate accommodation on discharge from hospital so that they can receive ongoing clinical care which requires early specialist planning. • People who receive early access to therapy and reablement during a recovery period following a hospital admission are more likely to have reduced or negated longer term care needs. Other agencies, such as voluntary sector, can also be engaged to support people which is less likely when planning is less considered and proactive. • If we are concentrating on people going home then the bed based resources can be utilised for those patients that actually need them and currently might be waiting for a bed whilst patients that don’t need them are utilising them. Using the right resources for the right people will improve outcomes for all concerned. • Currently as resource availability changes so rapidly it is difficult to respond to everybody in a uniform manner. Patients with the same needs and circumstance may leave hospital on differing pathways and then have different outcomes depending on the available resources at any one time. This proposal will reduce this risk prioritising home based discharge for all patients.
Responsible Service Manager	

Date	

Approved by Senior Manager	
Signature	
Date	

Potential Impact

Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
Age	Older people are at increased risk of deconditioning and loss of independence the longer they remain in an unfamiliar bedded environment. People who are confused or who lack capacity, for example people with dementia need to be supported to understand the hospital discharge process and options open to them.	The proposal seeks to ensure that wherever possible people will have their long term needs assessed in their home environment helping them to remain independent. The proposal seeks to ensure that people's needs are identified as early as is possible through pre-planning and having access to expertise that can support communication and advocacy in relation to hospital discharge and ongoing assessment of long term needs
Mental Health	Hospital admission can generally effect people's mental health and further negatively impact on those people that have established mental health needs. People have established routines, medication regimes, networks and dependencies that need to be accounted for together with the potential for impaired communication and decision making capacity.	This proposal focuses on early planning and where appropriate engaging specialist support and known support networks in an effort to ensure that the patient is as involved as possible in the discharge process. Supporting people to return to the place that they came from on discharge, wherever possible, reduces the

Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
		impact caused by taking people away from familiar surroundings routines and networks.
Disability	People with disabilities and complex health needs are at increased risk of remaining in hospital as finding alternative care can be difficult to source. Communication can be an issue for some people however it is important that people have a full awareness of the options and processes involved related to hospital discharge. People with autism may require extra support with communication and interpretation together with changes in relationships, environment and routines. This can require focus and can be difficult in a busy environment such as a hospital ward.	The proposal seeks to ensure that people's needs are identified as early as is possible through pre-planning and having access to expertise that can support communication and advocacy in relation to hospital discharge and ongoing assessment of long term needs. Early involvement from the community increases the opportunity to engage with people with autism, identifying appropriate support including advocacy or people's own established networks to increase involvement and reduce anxiety and uncertainty. Discharging people with autism back to the environment that they came can reduce the level of uncertainty and further assessment is likely to be more realistic and appropriate if undertaken in a person's own home.
Homelessness	Homeless people are more likely to have complex needs that require early support. It is important that established support networks (e.g. MH services, homeless healthcare, primary care vol orgs), are involved in supporting discharges particularly for those	Early community planning for hospital discharge is important in engaging the appropriate networks to support homeless people once they have been discharged. The proposal seeks to engage this level of involvement at the

Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
	people discharging to the street. Homeless people requiring onward care following discharge, for example those who have reduced mobility, require ongoing clinical care such as oxygen therapy etc, will require a safe appropriate accommodation to be discharged too can be challenging particularly if the individual has no recourse to public funds or have behaviours that may be challenging in some environments.	earliest point possible. Securing safe appropriate accommodation requires early planning and coordination which forms part of this proposal. There is currently further work underway to develop the proposed pathways to further support homeless people.
Gender Reassignment	No negative impact	
Marriage and Civil Partnership	No negative impact	
Pregnancy and Maternity	No negative impact	
Race	The hospital discharge process requires that patients and their relatives understand the options and the follow on activity in the community. This requires that where there are language barriers that people are given equal opportunity to understand and ask questions.	The proposal seeks to identify people who need extra support e.g. language barriers, at an early stage and source the appropriate support required to risk assess and pre-plan what is required to support a safe discharge.
Religion or Belief	No negative impact	
Sex	No negative impact	
Sexual Orientation	No negative impact	
Community Safety	No negative impact	
Poverty	No negative impact	
Other Significant Impacts		