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 proposals and consider mitigating action.

Name or Brief Description of Proposal	Re-Procurement of the Joint Equipment Store

Brief Service Profile (including number of customers)

This report seeks Joint Commissioning Board (JCB) approval to proceed with a proposal to mainstream a hospital discharge pilot for patients/clients on Pathway 3 with complex needs. This follows a substantial pilot period and a further subsequent redevelopment of the model based on the learning from the pilot which was outlined in a report presented to JCB in February 2019.

Background

Three pathways for discharge have been developed to provide a standardised approach, which is now recognised across the whole South West System.

- **Pathway 1 Simple discharges** – these are managed by the hospital staff through trusted assessment with support as necessary from the Integrated Discharge Bureau (IDB) and strong links back to the patient's/client's community care team who will proactively work with the hospital. Primarily this includes care package re-starts and return to home or previous placement. Ward staff are responsible for identifying and assessing these patients and refer onto the discharge officers within the hospital to organise discharge.
- **Pathway 2 Supported discharges** – these discharges are managed by the Southampton Urgent Response Service (URS) which is part of the Integrated Rehab and Reablement Service. A D2A scheme using home care is now well established and the URS will in-reach into the hospital to work with ward staff to facilitate discharge. This includes those situations where additional support in the community is required for example a long term care package, rehabilitation, reablement or bed based care. Ward staff are responsible for identifying and directing these patients to the URS which will then facilitate discharge.
- **Pathway 3 Enhanced discharges** – these discharges are managed by the IDB and Hospital Discharge Team (HDT). This involves those patients requiring complex assessments or those with obviously complex long term

care needs. This can include safeguarding concerns, those lacking mental capacity and those likely to be eligible for Continuing Healthcare. Ward staff are responsible for identifying and directing these patients to the IDB which will then facilitate discharge.

Discharge to Assess (D2A) is recognised nationally as best practice for ensuring timely hospital discharge and is defined as:
"discharge to assess will involve people who have ongoing complex care need but have been clinically optimised such that they no longer require an acute hospital bed for this care and their assessment can take place outside the hospital setting, in their local community, ideally in their own home or if not possible a setting as homely as possible".

The benefits of assessing people's long term care needs outside of the hospital environment have been well documented and are predicated on the principle that people feel more empowered and are better able to function in a less acute setting leading to a more informed and accurate assessment of their needs. This can reduce ongoing requirements and care costs.

The focus of this paper is a subgroup of patients on Pathway 3 who have complex needs some of whom will potentially be entitled to Continuous Healthcare funding. This cohort of patients is relatively small (averaging 8 a month) however they are likely to require specialist assessment and potentially will have long term high cost needs.

The proposal is to mainstream the model that has been piloted.

In order to facilitate this, it is estimated that up to 10 nursing home beds will be required at any one time for the period during which clients are assessed, based on 2 clients a week and an average assessment period of 5 weeks. It is proposed that the assessment beds comprise a mix of block contracted beds (6 beds) and spot purchased beds (4 beds), thereby enabling some clients to go straight to their long term destination where possible whilst also maintaining the positive relationship that has been developed with the current contracted nursing home provider for this scheme.

The proposal is for a pooled budget with contributions from the CCG and Council to be established to cover the costs of the 10 assessment beds (6 contracted beds and 4 spot purchased beds).

Summary of Impact and Issues

The main issue, based on the pilot phase, was that some patients that were eligible for D2A refused to enter on to the scheme, the primary reasons being:-

- The location of the proposed interim placement wasn't close to their home or family,
- That they would be "forgotten" once out of a hospital bed and would be stuck in a placement that they hadn't chosen.

These issues have been mitigated against as part of the pilot through the use of spot purchasing arrangements to allow for placements to be as close to people's homes as possible. One of the principles of the scheme is to also try to place people in nursing homes which are likely to be their final destination (nearly all Pathway 3 D2A patients are assessed as requiring a nursing home placement). Ward based awareness and confidence in the scheme has also supported patient discussion at an earlier stage which also helps manage any concerns they or their families might have about the pathway.
Potential Positive Impacts
The benefits of assessing people's long term care needs outside of the hospital environment have been well documented and are predicated on the principle that people feel more empowered and are better able to function in a less acute setting leading to a more informed and accurate assessment of their needs. Risks of prolonged stays in hospital after a person is well enough for discharge also include hospital acquired infection and deconditioning. This proposal addresses this by ensuring that people can leave hospital as soon as they are fit for discharge.

Responsible Service Manager	Jamie Schofield
Date	23/09/2019
Approved by Senior Manager	Donna Chapman
Date	23/09/2019

Potential Impact

Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
Age	The model supports primarily older people to have their needs assessed in a community setting reducing the inherent risks associated with unnecessary hospitalisation e.g. reduced mobility, hospital acquired infection.	Not applicable – this proposal would be a positive impact by enabling people to leave hospital sooner and therefore reduce the risks associated with prolonged hospital stays.
Disability	As above this group of patients require assessment in an environment that reflects, as best as possible, their long term surroundings particularly in relation to mobility, equipment, personal needs etc.	Not applicable – this proposal would enable a person's long term needs to be better assessed and therefore met by enabling the assessment to take place in an environment which is more homely.
Gender Reassignment	No specific impact	
Marriage and Civil Partnership	No specific impact	

Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
Pregnancy and Maternity	No specific impact	
Race	There is a potential impact in terms of being fully informed/involved and understanding the pathway and assessment process. There is also a need to ensure that people are confident that any home they might move on to is able to support their cultural needs.	The wards and discharge teams are much more aware of the D2A pathway and are encouraged to discuss these potential options with patients and their families at the earliest opportunity. This would when necessary include use of interpreters. The eligibility assessment for D2A includes the requirement to identify individual needs that support the Care Placement Service in identifying a suitable placement. The assessment undertaken in the community is vigorous and holistic incorporating an individual's cultural and religious needs.
Religion or Belief	As above it is important that patients religious beliefs form part of the assessment process both in terms of eligibility for D2A and the assessment process undertaken in the community.	The wards and discharge teams are much more aware of the D2A pathway and are encouraged to discuss these potential options with patients and their families at the earliest opportunity. This would when necessary include use of interpreters. The eligibility assessment for D2A includes the requirement to identify individual needs that support the Care Placement Service in identifying a suitable placement. The assessment undertaken in the community is vigorous and holistic incorporating an individual's cultural and religious needs.
Sex	No specific impact	

Impact Assessment	Details of Impact	Possible Solutions & Mitigating Actions
Sexual Orientation	No specific impact	
Community Safety	No specific impact	
Poverty	No impact specifically related to this proposal. The D2A pathway is free to all patients. The outcome of the assessment will determine whether they are entitled to CHC or social care funding, or potentially self-funding if they are above social care financial eligibility thresholds. This is no different should the person be assessed in hospital or through the D2A pathway.	Not applicable
Health & Wellbeing	The D2A assessment process will reflect the wider health and social care system to ensure that service provision is joined up and person centred.	Staff undertaking the D2A assessments are highly experienced and have a broad knowledge of the wider system. The Enhanced Health in Care Homes programme is partially established in all Southampton nursing homes with further roll out over the next year with the primary care element.
Other Significant Impacts	No specific impact	