HAMPSHIRE COUNTY COUNCIL

Decision Report

Committee:	Cabinet
Date:	16 March 2021
Title:	Health and Social Care System Resilience during COVID-19
Report From:	Director of Adults' Health and Care

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Purpose of this Report

1. The purpose of this report is to update Cabinet on the key activities undertaken across the health and social care system to maintain system resilience in the discharge of people from hospital settings during the response to COVID-19.

Recommendations

2. Cabinet is asked to support;

   a) The continuation of discharge pathways and funding arrangements, put in place through NHS Discharge funding and our collective response to the pandemic, to maintain and build on progress and performance described in this report and in-line with the White Paper - Integration and Innovation: working together to improve health and social care for all, published on 11 February 2021.

3. Cabinet is also asked to note;

   a) Overall performance in the most extraordinary circumstances to support residents to be discharged from hospital settings and return to their appropriate place of residence.

   b) The efforts of all staff and partner organisations in maintaining safe, appropriate and resilient discharge pathways, within a new national operating framework, introduced at pace, in the spring of 2020.

   c) The fundamentally changed nature of the health and care sector as a consequence of its response to COVID-19 and an ambition to see provision, relationships and outcomes described in this report continue, in line with the Council's approach to supporting of our residents.

Executive Summary

4. This report seeks to provide an overview and update Cabinet on key activities and issues related to acute hospital system resilience throughout the period of response to COVID-19. The situation has been incredibly challenging and dynamic in terms of the issues faced and the response required.

5. In response to the COVID-19 pandemic, on 19 March 2020, the Government issued new hospital discharge guidance for all NHS trusts and local authorities. This guidance also formally suspended the reporting of Delayed Transfers of Care (DToC) a key interface between the NHS and Local Government, from mid-February 2020.

6. This interim guidance for the COVID-19 period required the NHS and Social Care to take a new single system approach, with the goal of rapidly discharging hundreds of patients from hospital to maximise capacity to treat people with acute COVID-19 (Covid) symptoms. The discharge of people was in anticipation of creating maximum 'surge' capacity in acute hospital settings in the Spring of 2020. Thankfully this capacity was not required at that time. Changes in legislation facilitated this and additional funding was made available to the NHS to provide / or arrange care for individuals leaving hospital during the crisis period. This change in funding and discharge commissioning responsibilities has had a transformative impact in this key interface in the role of the NHS and Local Government.

7. Furthermore, on 21 August 2020, NHS trusts and local authorities were issued with updated hospital discharge guidance. This guidance reinforced the approach taken under the interim guidance and gave specificity to new ways of working and funding in the short / medium-term, with additional funding continuing to be made available to enable people to leave hospital, albeit, for more specific purposes and for a more limited, 6 week period. Subsequently, a new National Social Care Winter Plan was produced in the early autumn of 2020.

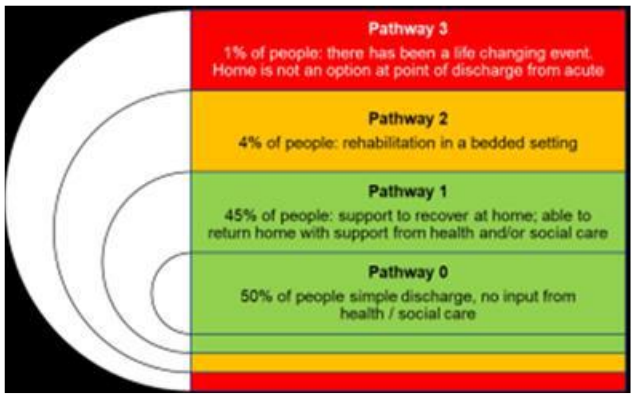
8. Performance to maintain flow of patients through the discharge pathways described in both the interim and subsequent guidance has seen the adoption, at pace, of new ways of working, new facilities and multiple step-changes in the prevailing approach to provide care. A range of approaches have also been brought about through learning from successive waves of the pandemic and its subsequent impact on NHS and social care settings.

9. Overall, we have seen some 7,000+ people across Hampshire's acute hospitals supported to be discharged – a rate of 150+ people per week; either returning home with additional support, returning to a care home setting with additional support or being admitted to temporary discharge to assess bed-based facilities (including some temporary 'hotel' bed facilities commissioned by the Clinical Commissioning Groups (CCGs) in the spring to create surge capacity) before moving to a permanent destination / service level / type. It is important to underline that the completion of an assessment to determine an ongoing level of support follows the person once they have moved out of acute hospital settings; delay through completion of an assessment whilst in an acute bed has been removed from the discharge process – the new

approach being called Discharge to Assess (D2A). We have also seen the repurposing of some care home capacity, as well as the establishment of new D2A bed-based services. Fundamentally, national arrangements for the NHS to fund discharge support for up to 6 weeks has enabled this new, dramatic approach.

Summary of the key policy and process changes

10. The new hospital discharge system arising from all the current guidance is based on the principle that unless required to be in hospital, patients must not remain in an NHS bed and acute and community hospitals must discharge all patients as soon as it is clinically safe to do so. Transfer from the ward should happen quickly, but safely. This has been further enhanced by guidance relating to the approach that must be followed to both test people for COVID-19 in advance of discharge (brought about in mid-April 2020) and also when someone can be discharged from hospital when they are COVID-19 positive. Whilst the guidance is in place through emergency measures, elements of the new ways of working will, inevitably, continue into the post-COVID-19 operating model.
11. The above changes have combined to bring about a dramatic (positive) impact on what used to be referred to as delays in transfer (DToCs) and marked improvements to near relatively few delays (people now being identified as having a status of Medically Optimised for Discharge (MOFD)) have been noted by the systems around patient discharges. Additionally, formal recording of DToC was suspended in mid-February 2020.
12. As a reminder – the guidance sets out pathways for people being discharged from hospital, as shown in the diagram below:



13. The requirements set out in the guidance are that:
    - Systems should work to a D2A model.
    - Assessments and planning for ongoing care will take place at home or in a community (D2A) setting, not in a hospital.
    - ‘Home first’ should be the aim for all patients, wherever possible.

- Every discharged patient should be followed-up within 24 hours of discharge (ideally same day) by a lead professional or community multi-disciplinary team (MDT).
- There should be 7 day per week working for all planned discharges between 8am and 8pm, and
- Discharge to an interim care bed (D2A) or Designated Setting (where a person has tested COVID-19 positive) for up to 6 weeks should happen where a return home or usual care setting was not appropriate / available.

14. In all circumstances NHS Covid funded discharge support is available, albeit time limited, at this point into the early part of 2021/22.
15. The guidance has further required enhanced and deep multi-agency working to support what is a complex process, with several changes in responsibility and / or joint ways of working:
    - Acute hospitals remain responsible for Pathway 0 discharges (simple discharges)
    - Community providers (Hampshire County Council with Southern Health and Primary Care Networks) are responsible for Pathways 1-3 discharges and the tailored support required in each instance, and
    - Multi-agency collaboration is required to support the discharge process of all Pathways – with Single Points of Access (SPoAs) and co-ordination strongly embedded to streamline processes.
16. To enable this approach, we have developed a new system-wide tracker of available system capacity, as well as ensuring each person is tracked and followed through their discharge journey / destination; to D2A care home provision, community beds, hospices and residents own homes.

Hampshire's approach to implementing the national guidance

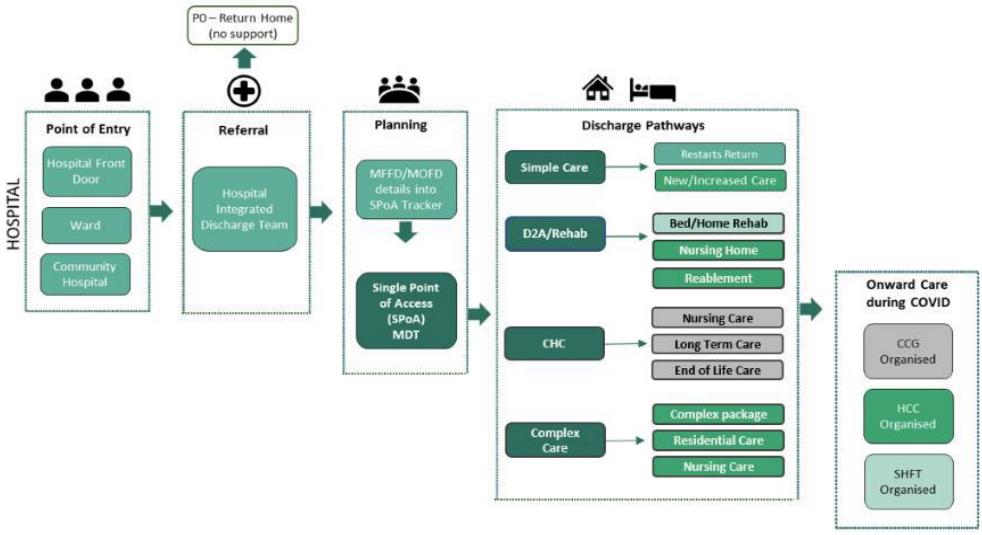
Single Points of Access (SPoAs) for each acute hospital footprint

17. Each acute hospital system in Hampshire has developed a discharge process, in common across our whole geography, for people needing onward health and social care. All referrals made into a multi-disciplinary, multi-organisational Single Point of Access (SPoA).
18. The SPoA manages the D2A approach in order to rapidly and appropriately discharge individuals on pathways 1-3 from hospital, when MOFD. Oversight of the ongoing assessment of need following discharge is provided. From the notification of a person being discharge ready, through to leaving the acute hospital, a timeframe of 24 hours is being routinely achieved, though can and does take longer in the more complex cases; where necessary for patient safety / safeguarding or other reasons.
19. This is a radically different way of working with our system partners and the SPoAs bring together shared teams across all key operational services. The operational leads are responsible for the daily processes and ensuring safe

discharge using the principles of D2A. There is shared operational management accountability for SPoA functioning. Adult Social Care senior managers are well represented in leadership roles in the SPoA.

20. Under the new arrangements, referrals into these SPoAs (via a digital process) come from acute hospitals and community hospitals for all care pathways. Each of the SPoAs comprises a multi-disciplinary team, including West Hampshire CCG Continuing Health Care Team, Southern Health Foundation Trust staff, Hampshire County Council Hospital Social work staff and Reablement staff. These staff work closely with Acute Trust staff from the Hospital Discharge Teams and colleagues with links to Hampshire County Council Brokerage. Ambulance services and others may also be involved. Hampshire's approach to this new model has been a lead regionally and has significantly influenced opportunities that we see for discharge operations in the future.

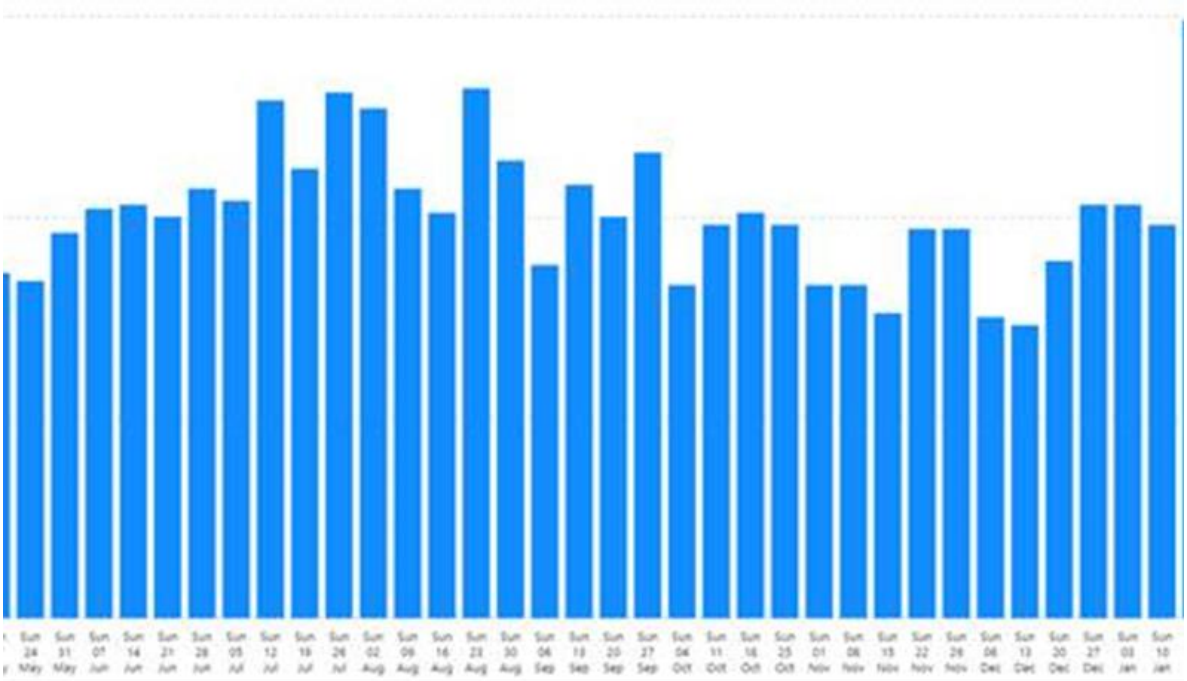
21. The diagram below illustrates, at a high level, this new COVID-19 discharge process;



Impact and Performance

22. Since February 2020, and in the light of these changes, recording of Delayed Transfers of Care have been suspended by the NHS, meaning it is not possible to directly monitor the impact of the new arrangements when viewing them in light of the previous DToC reporting. However, despite there being no national figures, internal tracking by the Trusts confirm that bed delays of any kind have reduced to a fraction of those previously reported. It is important to identify that measures now in place are based upon NHS discharge funding. This has removed the critical interface which has been a feature of the prevailing DToC process; e.g. who is funding what and who needs to be in agreement that this is appropriate. Further information on the new discharge funding arrangements is outlined, in paragraphs 25 and 30, below.

23. The chart below shows acute hospital discharges from April 2020 to February 2021;



24. It is also worth noting that of these 7,000+ people supported some 3,150 are new to social care support. Of these 85% of people went either into an interim bed or straight home with additional short-term support. With fewer than 2% of new clients going into a permanent residential or nursing care placement from hospital. This reduction of permanent care home placements directly from hospital has been a key outcome that the new services have sought to achieve. However, this represents broader care sector risks into the medium-term which is likely to lead to some care home re-setting in terms of home closures / reduced overall bed-base.

25. Hampshire County Council is continuing to be successful at accessing external NHS funds in the form of a Discharge Fund (DF) to support the stand up and delivery of these new arrangements and services to care for patients during COVID-19. Operating under a national framework, this fund has operated two main Discharge Schemes to enable recurring and non-recurring funds to be allocated to support discharge, Reablement and other winter specific pressures such as, additional support to the most frail of our users during COVID-19.

26. As at the end of October 2020 Hampshire County Council had claimed a total of £13.2m from the NHS Discharge Schemes. This claim amount has been made in accordance with the scheme guidance and all expenditure has been agreed with the Clinical Commissioning Groups (CCGs) as eligible expenditure. It is currently forecast that by the end of the financial year the total claim will be approaching up to £24m across the schemes. It is important to identify that pathways and new provision referred to throughout this report are subject to the funding arrangements put in place through our response to COVID-19 continuing. Should either the national NHS Discharge Fund not

continue or NHS resources not be available to support these approaches, then regrettably, Hampshire County Council will move to de-commission such provision within the remaining timeframe of the currently available funding.

27. Expenditure against these schemes falls into two categories:
    - Eligible care provision costs
    - Services commissioned / provided on behalf of and at the request of the CCGs.
28. In respect of the latter this has included for scheme 1, the following in the first six months to the end of September 2020:
    - Extending the capacity of the Hampshire equipment store from 5 day working to 7, including increased equipment provision
    - Procuring a countywide rapid discharge scheme and increased Hampshire County Council Reablement resources to facilitate increased flow from hospitals
    - Furnishing increased discharge capacity within temporary Hotel sites and commissioning care provision
    - Increasing hospital care management resources to ensure assessments are timely to support rapid flow and
    - The introduction of Clarence Unit in the South-East of the County - a Discharge to Assess (D2A) unit of up to 80 beds, with 25 of these beds presently designated for COVID-19 positive patients.
    - The re-purposing of HCC Care facilities, mainly Willow Court and Forest Court to provide additional D2A capacity in the North and Mid, and South-West sub-systems
    - Increasing numbers of beds for more complex users to help free up capacity needed for COVID-19 ventilated bed spaces in Acutes.
29. From October 2020, within scheme 2, the above have continued and have begun to increase in volume. In particular, D2A bed-based capacity has expanded, using more in-house HCC Care capacity to meet the needs of the hospital systems. Of late, this has further increased across the wider social care sector, in light of acute hospital admissions.
30. Furthermore, the additional hospital care management capacity, along with increased resource for Hampshire County Council Reablement have extended further as they are now enshrined within the overarching Integrated Intermediate Care (IIC) and SPoA initiatives. Whilst NHS funding for these initiatives is, in the main, temporary to 31/03/2021, there are some elements that have been secured as permanent funding. Furthermore, it is hoped that the South West Hampshire and South East Hampshire systems will be able to confirm all temporary funding as permanent before the end of the financial year.
31. In this financial year, we estimate that some £24m of funding will have been made available to fund discharge support across pathways 1-3, much of this

is to enable Hampshire County Council to deliver additional services on behalf of the NHS (such as discharge to assess and costs incurred through the previously established 'care hotels'), as well as ensuring that support for up to 6 weeks is available for all people subject to the hospital discharge pathway. Work remains ongoing on the cost recovery and reimbursement arrangements with the CCG Partnership and local system partners.

32. Further performance worthy of particular focus include the use of short-term bed-based care as alternatives to making permanent admissions to care homes - the development of specific D2A bed-based care. At the vanguard of this approach, is the creation of the Clarence Unit which supports discharges from Queen Alexandra Hospital. This unit provides an average of 21 to 28 days support to individuals who are unable to return home upon discharge to aid their recovery and rehabilitation. Therapists and social workers work on site alongside the care staff to optimise the person's reablement potential and to carry out Care Act assessments with a focus on how someone could successfully return home. Since opening, the unit has supported more than 280 patients and has recently increased its capacity to 73 beds. Outcomes for clients benefitting from the Clarence service offer have been very favourable with just under 25% requiring (moving on to) long-term residential and nursing care at the end of their stay. Prior to the D2A operation, most would have been discharged from hospital straight to a permanent long-term care solution.

33. Currently the D2A approach is being replicated in other HCC Care homes, most notably at Willow Court and Forest Court. It is also available in some independent sector homes. At the start of January there were 168 beds across the County, which includes a number of designated beds for COVID-19 positive patients. Close performance monitoring across all these homes is in place and work will continue to ensure that the service set-ups and service performance and outcomes are concentrated around the main settings and optimised to replicate the results that are being achieved at Clarence Unit.

34. Additionally, we have established a new Rapid Discharge Service (RDS), designed to rapidly enable people to return home within 2 hours of a discharge decision or to avoid an admission altogether. In total, the RDS has supported 529 discharges from hospitals across Hampshire. At the end of receiving this service, 42% of clients required no further long-term services from Adults' Health and Care, with 37% going onto receive longer-term domiciliary care. The remaining 21% of people were either admitted to hospital, a care home setting or, given that they were in a palliative phase, sadly died.

35. Overall, our Reablement services, through a transformation programme which commenced some three years ago have seen a total of 17,621 371 referrals in this financial year (including Occupational Therapy and other services) – of which 6,346 are for people being discharged from acute hospital settings and almost 1,050 people from other hospital settings. However, it is important to recognise that we are now seeing some 60% of referrals being received by our Reablement Service to support people to remain in the community rather than enter hospital settings. Alongside this transformed balance in referral

patterns is that people, on average, remain in the service for 19 days – some 2 days less than the target and a remarkable 16 days less than when the transformation programme commenced. This stunning effort to reduce pressures upon NHS services can also be witnessed across all HCC's adult social care services and across all our operational teams, working with providers and partners.

Looking forward

36. The marked uplift in volume and pace of discharge seen in this year has been a significant challenge to sustain, especially in light of the impacts upon the care home sector in the spring / early summer of 2020 when we saw the devastating effects of COVID-19 on care home settings. To its considerable credit the care home sector, whilst still fragile, has recovered some confidence and implemented robust COVID-19 secure procedures in the second half of this year. However, the impacts on the social care workforce across all elements of the whole, wider social care sector will remain into the medium / longer term. The impacts of staff fatigue, isolation and trauma of staff and people receiving support, will clearly continue to cast a significant shadow and will require dedicated recovery activity.

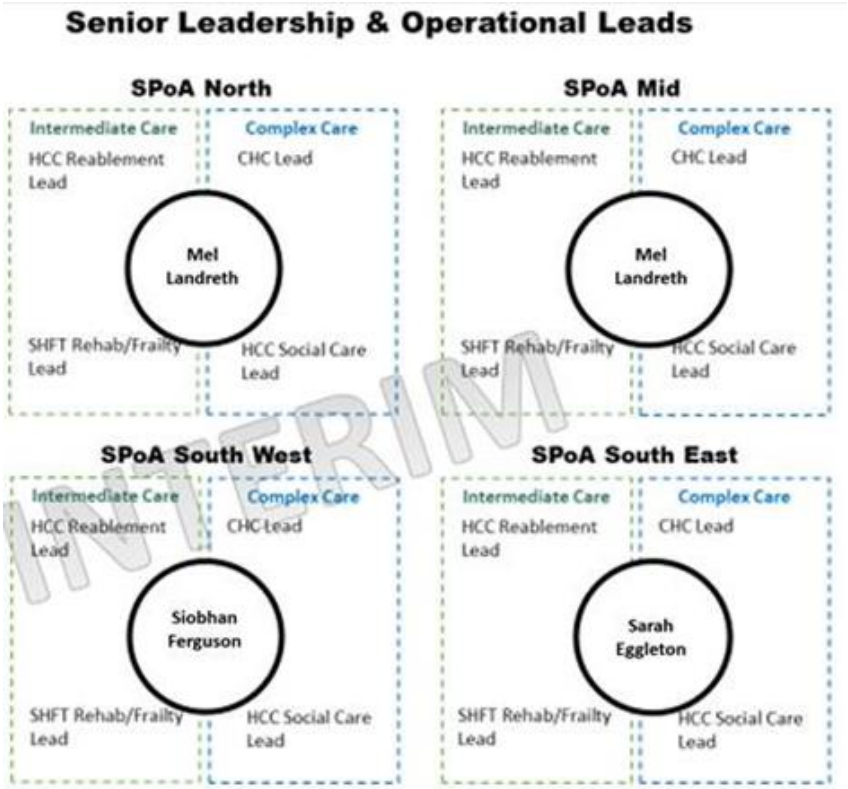
37. Additionally, new challenges relating to lower numbers of permanent admissions and sector-wide issues relating to insurance cover have come increasingly to the fore in recent weeks/months. These are issues that Hampshire County Council are actively supporting the sector to address. However, contextually we have seen the commissioning of a quarter fewer new permanent admissions through HCC, whilst deaths in care home settings (both those expected and those resulting from COVID-19) has seen a contraction of circa 20% of people in permanent care home settings overall. Whilst permanent admissions through local authority / NHS commissioning equate to approximately 40% of the care home sector the reductions in the sector over the past 12 months lead the care home market to be in a fragile short-term position. HCC commissioners will continue to work with the sector, though there is a high risk of some home closures and market re-setting during the comping period.

38. The domiciliary care sector has remained robust in its ability to support residents throughout 2020. This is testament to the market development transformational work that the Department successfully focussed on over the past 2 years. However, since the rapid increase in community transmission and number of COVID-19 cases seen since late December 2020 concerns in the short-term have increased.

39. It is hoped the roll-out of vaccination across the highest priority groups and the current slowing in COVID-19 transmission rates will enable the sector to recover. However, inevitably in response to the impacts of the pandemic the NHS will need to recover planned / elective care through the remainder of this year (and beyond) and maintain the vaccination programme meaning that pressures upon the wider health and social care sector and the social care provider market will continue.

System governance

40. New interim governance arrangements have been put in place between NHS and social care partners to support robust and consistent decision making across our operational area, as shown in the diagram below. As well as the governance arrangements in place for each SPoA, a Hampshire wide Discharge Leadership Group brings together director-level and senior level organisational leads to make decisions about issues that need to be resolved at a Hampshire scale or where there is a need for greater organisation wide oversight. This Group is chaired by the jointly funded Hampshire County Council / NHS Director of Transformation – Patient Flow & Onward Care.



Conclusion

Learning and Looking Forward

41. An unparalleled integration and transformation remains ongoing with our system partners as a result of COVID-19 and joint ambitious solutions are now more of an expected norm within the system partnership. The stand-up of new and effective shared service architecture set out above has enabled the safe and fast-paced discharge of thousands of patients across Hampshire, working more closely than ever as a system partnership with singular focus.

42. The system partnerships have agreed that the new service architecture must be maintained and our shared ambition and appetite for this is high. System partners have worked well together in difficult circumstances to put a robust

new process in place with forward momentum. We remain focussed on not 'slipping back' to old ways of working, but pressures on NHS services to recover and restore elective care pathways and the costs of the new arrangements remain as risks as does a myriad of sometimes challenging policy guidance for social care and the NHS.

43. Furthermore, it is key that Hampshire County Council works on a deeper and at the same time more impactful collaboration with CCGs and Health commissioners to ensure that there is sufficient ongoing community home and bed-based capacity to serve the varying discharge needs of Hampshire residents.

44. A key suite of performance dashboards is in place and will be further developed for the SPoA's to provide the information necessary to support forward joint commissioning, performance monitoring, national reporting and future business cases.

45. In addition, a number of different activities are underway across the system to review Hampshire's response to the national discharge guidance, to review actions taken and to assess future opportunities for a sustainable SPoA and D2A model.

46. **Forward direction activities include:**

- On 11 February 2021 HM Government published the White Paper Integration and Innovation: working together to improve health and social care for all (Integration and Innovation: working together to improve health and social care for all). This sets out the direction of travel to create increased integration and collaborative working locally between the NHS and local government. These proposals are entirely in line with work underway across Hampshire and as such represent a significant opportunity to build upon work undertaken jointly through our response to the pandemic. It also creates the opportunity for increased strategic and functional alignment through the development of the Hampshire health and care system within the Integrated Care System development identified in the NHS Long Term Plan and the operation of the Health and Wellbeing Board and associated arrangements.

- Confirmation of continuing / future investment with NHS partners for the new pathways and resources identified in this report for 2021/22 and beyond – both for capital and revenue funding

- Case studies and tactical changes to monitor the quality of COVID-19 care to aid our learning of the impacts of this disease in our ongoing care of users

- A long-COVID-19 national pilot (external fund of £300,000 attained to be shared) to help establish a hub of HIOW expertise to drive clinical and care learning and excellence across the partnership for complex, post-COVID-19 conditions

- Tools have been developed both to log immediate risks and issues for resolution in each SPoA as well as to track risks, assumptions, issues and

dependencies more strategically to feed into the learning from this complex implementation process

- Rapid Insight SPoA Discharge Case Study work by Wessex Academic Health Science Network, which will review a number of patients on their experience of the discharge process
- Care Governance overview of assessment practice and Care Act compliance for onward care
- Healthwatch Hampshire survey on health and care advice and help during COVID-19
- Quality impacts and case studies to learn from patient and user experience and patient stories of care during COVID-19, some of which are remarkable
- Stakeholder evaluation exercises in each system have looked at what has worked well and what could be improved moving forward.
- High uplift of activity and capacity to support wave 3 is now underway and the services remain at a heightened state of performance and delivery into March 2021.

REQUIRED CORPORATE AND LEGAL INFORMATION:

Links to the Strategic Plan

Hampshire maintains strong and sustainable economic growth and prosperity:	no
People in Hampshire live safe, healthy and independent lives:	Yes
People in Hampshire enjoy a rich and diverse environment:	no
People in Hampshire enjoy being part of strong, inclusive communities:	Yes

Other Significant Links

Links to previous Member decisions:	
Title	
Direct links to specific legislation or Government Directives	
Title	Date
White Paper - Integration and Innovation: working together to improve health and social care for all	11 February 2021
COVID-19 updated hospital discharge guidance. COVID-19 Hospital Discharge Service guidance	21 August 2020 20 March 2020

Section 100 D - Local Government Act 1972 - background documents

The following documents discuss facts or matters on which this report, or an important part of it, is based and have been relied upon to a material extent in the preparation of this report. (NB: the list excludes published works and any documents which disclose exempt or confidential information as defined in the Act.)

Document	Location
None	

EQUALITIES IMPACT ASSESSMENT:

1. Equality Duty

The County Council has a duty under Section 149 of the Equality Act 2010 ('the Act') to have due regard in the exercise of its functions to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct prohibited by or under the Act with regard to the protected characteristics as set out in section 4 of the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation);
- Advance equality of opportunity between persons who share a relevant protected characteristic within section 149(7) of the Act (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation) and those who do not share it;
- Foster good relations between persons who share a relevant protected characteristic within section 149(7) of the Act (see above) and persons who do not share it.

Due regard in this context involves having due regard in particular to:

- The need to remove or minimise disadvantages suffered by persons sharing a relevant protected characteristic that are connected to that characteristic;
- Take steps to meet the needs of persons sharing a relevant protected characteristic that are different from the needs of persons who do not share it;
- Encourage persons sharing a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionally low.

2. Equalities Impact Assessment:

Health and Social Care System Resilience during COVID-19

Accountable officer: Graham Allen, Director of Adults' Health and Care
Date of assessment: 04/02/2021

Description of current service/policy

During the Covid-19 period, Adults' Health and Care has worked with the NHS to take a new single system approach, with the goal of rapidly discharging thousands of patients from hospital during 2020/21 to maximise capacity to treat people with acute Covid-19 symptoms. Changes in legislation have facilitated this and additional funding has been made available to provide care for individuals leaving hospital during the crisis period. The joint goal has been to safely care for and discharge patients to the most appropriate care settings, including some now to dedicated care home settings ("designated") for Covid-19 exclusively.

Geographical impact:
All Hampshire

Description of proposed change
Each system surrounding Hampshire's acute hospitals has developed a new discharge process in line with National directives. Referrals for discharge are now made into a multi-disciplinary, multiorganizational Single Point of Access (SPoA). These SPoA bring together all organisations who would otherwise work individually on discharging people from hospital. The principle of 'Home First' is adopted, with those unable to go home usually going for a period of rehabilitation in a specialist care home before any longer-term decisions are made. Most people will return to their own home.

Impacts of the proposed change
This impact assessment covers Service users

Engagement and consultation
Has engagement or consultation been carried out? Yes

The new arrangements were introduced quickly to comply with emergency guidance being released by the Government. This limited opportunities to engage with service users and families. However, Adults' Health and Care has consulted and engaged with all relevant system partners in co-designing and developing the new system, for example NHS partners including GPs, commissioners and acute/community providers, and district and borough councils. Various opportunities to engage with and gain feedback from service users are now in place, including work by the Wessex Academic Health Science Network which will review a number of patients on their experience of the discharge process.

Statutory considerations
Impact Mitigation
Age: Low

There are a number of positive impacts of this new service model:
• Better coordination across services to ensure the most appropriate pathway is followed for each patient
• Individuals tracked through their journey, so long-term health and care needs can be assessed outside a hospital setting, which is likely to result in better long-term decisions being made
• Shorter hospital stays are likely to lead to less decompensation of frail elderly patients – typically, the longer you stay in hospital, the worse your outcome, therefore speedier discharge can often help.

The overall impact has been marked as 'low' however because the positives have to be balanced by a less favourable negative impact in that some patients may not get the choice of onward care they would ideally like in the short-term as the priority is to free up the hospital bed as soon as it is safe for the patient to leave.

The mitigation is that the initial onward care is only a temporary situation, and individuals are tracked throughout their care pathway to ensure that the most appropriate long term solutions can be found, preferably in the individual's usual place of residence.

Disability: Low The identified impacts for 'disability' mirror those for 'age'.
Sexual orientation: Neutral
Race: Low

We are aware that lack of choice in short-term onward care destinations for individuals coming out of hospital could impact on individuals being able to receive services that they feel are culturally appropriate in the short-term. However, the discharge to assess model which aims to assess long-term needs in the community should mitigate against short-term lack of choice by enabling more timely and personalised care planning for the longer term, out of the hospital environment.

Religion and belief: Neutral
Gender reassignment: Neutral
Gender: Neutral
Marriage and civil partnership: Positive

Reduced length of hospital stays and putting in place enhanced support at home may allow more couples to stay together in their own home for longer. Where one partner recuperates in a bedded facility, this may take pressure off the partner at home and reduce their need to take on very high levels of caring responsibility until their partner has made a greater recovery. In the short term, some couples may be apart for longer if post-discharge rehabilitation takes place in a bedded facility that is not accessible for geographical reasons or where visits in person are not yet possible. However, in the longer term, there should be benefits in recuperating outside a hospital environment.

Pregnancy and maternity: Neutral

Other policy considerations
Impact Mitigation
Poverty: Neutral
Rurality: Low

There are fewer care services available in rural areas if a bed-based solution is required. In addition, bed-based therapy services are being concentrated in centres of excellence or hubs. This hub approach should improve care outcomes but has a potential negative impact in that there is reduced short-term choice for the patient in their immediate onward care destination. This may particularly affect those patients who live in rural areas. This approach only applies to short-term onward care, hence the impact is considered 'low' rather than '.