Agenda item 13

Cabinet – 27th April 2016

Discharge to Assess Beds Pathway Services

Portfolio: Councillor Eddie Hughes, Care and Safeguarding

Service: Social Care and Inclusion

Related portfolios:

Wards: All

Key decision: Yes

Forward plan: Yes

1. Summary of report

1.1 This report follows the approval by Cabinet in October 2014 for delegated authority to be given to tender and award the Council's current contracts for Discharge to Assess Beds in nursing homes as additional support for people being discharged from hospital or to provide an alternative to hospital admission.

1.2 The current contracts secured provision for 40 block purchased discharge to assess care home beds, which have assisted the discharge of older people from the Manor Hospital with complex needs. However, the development of the Health & Social Care System Recovery Plan, in the last 5 months, suggests an alternative, model which should prove more appropriate to meet the presenting needs and be cost effective is detailed in this report.

1.3 Dialogue between the Council, Walsall Commissioning Clinical Group and Walsall Healthcare Trust is helping to inform an enhanced specification for the recommissioning of services which will be the subject of a future Cabinet report. This will include the outcomes of public consultation feedback.

1.4 This report seeks authority to carry out public consultation regarding proposals to change future 'Discharge to Assess' service delivery.

2. Recommendations

2.1 That Cabinet note that the contracts with providers for existing 'Discharge to Assess' provision of 40 care home beds, currently valued at £1.56m per annum in 2015/16, are due to expire on 31st October 2016 and approve the commencement of a public consultation process on the model and capacity of 'Discharge to Assess' services that the Council will provide from 1st November 2016 to meet the Council's continuing statutory duty.

3. Background Information

3.1 In October 2014, Cabinet was advised on the 'Joint Capacity Plan for Winter 2014/15' which was developed between Walsall Commissioning Clinical Group, Walsall Healthcare Trust and the Council which looked at ways of reducing Accident and Emergency attendance of people, particularly people aged over 75 years old. This plan aimed to reduce attendances to Accident and Emergency, reduce hospital admittance and reduce the length of stay and delays for those patients occupying a hospital bed who no longer needed medical treatment. This Plan stated it would be reviewed and may lead to further changes in time for 2015/16.

3.2 The Joint Capacity Plan for Winter 2014/15 has been replaced by the System Recovery Plan in December 2015 which is being monitored on a weekly basis with key stakeholders to improve the performance of the urgent care system.

3.3 The procurement process in 2014, resulted in 35 'step-down' and 5 'step-up beds' being block purchased from the successful contractors in 5 nursing homes and now funded within the 2015/16 Better Care Fund allocation.

The Health & Social Care System Recovery Plan

3.4 The Plan has suggested the consolidation and reconfiguration of bed based 'step-down' and 'step-up' provision and the releasing of funding to support alternative provision to help older people return direct to their homes will yield improved outcomes and enhanced performance of service delivery.

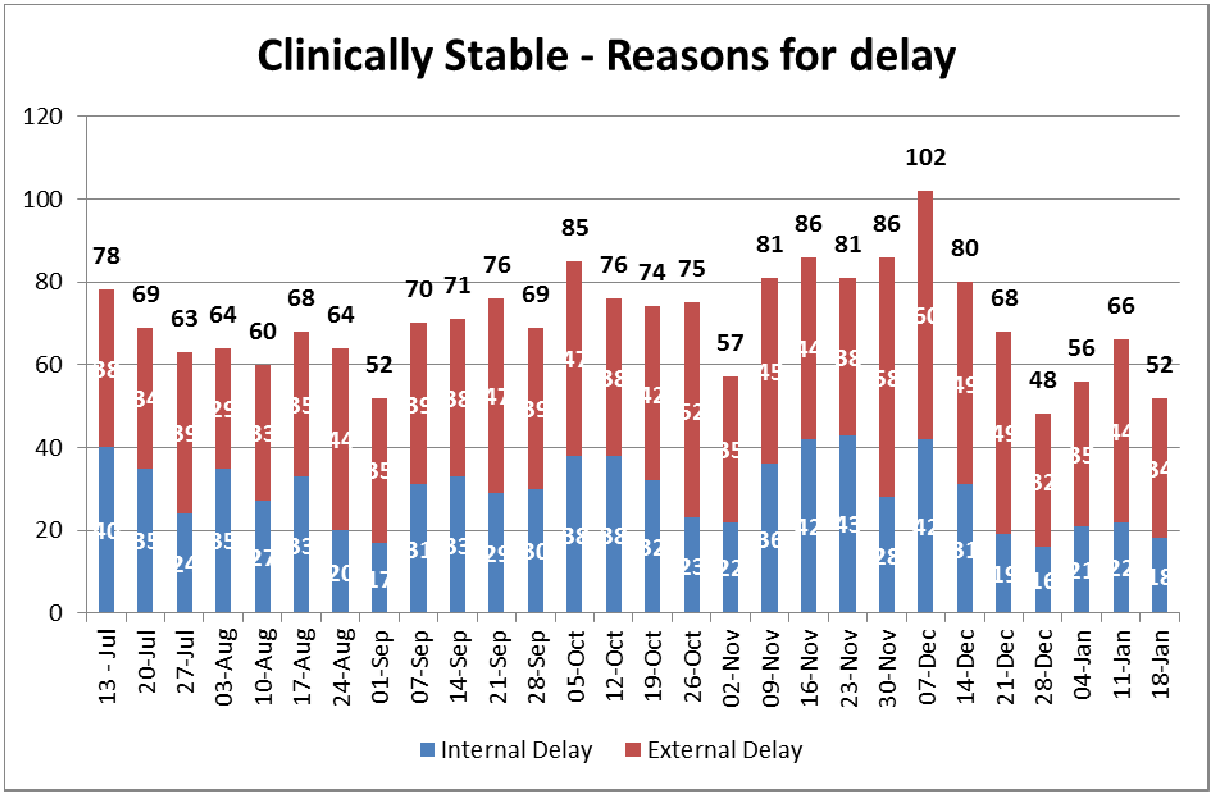
3.5 There is a link between discharges and Accident and Emergency (A&E) performance as delays in discharge can create capacity issues within the hospital that can have an impact on flow through A&E. There is a national target that no less than 95% people who attend Accident and Emergency should be seen, admitted, treated or discharged within 4 hours of arrival. The monitoring of the Plan has suggested by the end of December 2015 the standard had only been achieved once in over 18 months at The Manor Hospital.

3.6 Two important initiatives forming part of the 'Recovery Plan', attached as Appendix A have been underway since December 2015:

- A reconfigured 'Frail Elderly Service' is helping to divert hospital admissions from within the Accident and Emergency Department; and
- The 'Swift ward project' is serving to reduce delay and accelerate discharge for those who are medically fit for discharge.

The enhanced multi-disciplinary approaches to supporting older people to go home are showing significant improvements in reduced care home admission rates and patient discharges out of hospital and are critical to meeting Accident and Emergency targets.

3.7 Reductions in the numbers of patients medically fit for discharge have been dramatic and consistent since the monitoring commenced as set out in the graph below.



3.8 Although the existing model of 'Discharge to Assess' has supported this improvement, there have been some challenges, these can be summarised as:

- high numbers of readmissions to hospital,
- longer lengths of stay in 'Discharge to Assess' beds (beyond the expected maximum of 6 weeks) and
- proposed outcomes not being delivered; for instance, too many people are being admitted to long term nursing care – especially those with dementia.

3.9. It has also been identified, that a solely bed based model in care homes does not address the full range of needs of those being discharged from an acute hospital and therefore a future report to Cabinet will seek approval, following key stakeholders' consultation of an alternative configuration that is more focussed on discharge home to assess which is likely to require new contracts to be put in place.

3.10. The alternative model of 'Discharge to Assess' could reconfigure the existing funding to expand the capacity of alternative discharge pathways in line with the 'Recovery Plan':

- o Decommission the 40 care home beds in nursing homes and recommission 20 care home beds (including 3 beds for people with complex needs, e.g. mental health) with an enhanced specification.
- o The capacity in the 'bedded' pathway could be maintained by reducing the length of stay in the 'Discharge to Assess' beds;
- o Appoint additional capacity to the 'Social Care Support Team', extend the remit of the team to support all discharge pathways and improve identification of appropriate patients for 'Discharge to Assess' at home;
- o Arrange General Practitioner medical cover for the 20 'Discharge to Assess' beds to address and reduce high readmission rates (average 30%) – this has

been commissioned and funded directly by Walsall Commissioning Clinical Group to date;
- o Increase social care reablement capacity by 300 hours to enable return home; and
- o Commission an additional 400 hours of domiciliary care/homecare from the market to enable people to stay at home after discharge.

3.11 It is envisaged that the multi-disciplinary team including, social care staff and community health teams, supporting the existing 40 'Discharge to Assess' beds will remain but increase their capacity to provide increased focussed intervention to improve the length of stay, therefore, minimising the impact of bed reduction. The team will also work with hospital staff to support across each of the discharge pathways (both bed and community outcomes).

4. Council Priorities

4.1 The recommissioning of 'Discharge to Assess' pathways will contribute to the Council priority for *Improving health and well-being, including independence for older people and the protection of vulnerable people*. The way it will do this is through facilitating a timelier discharge from hospital thus reducing the risk of increased dependency. The reconfiguration of services could also ensure that more people discharge home directly from hospital thereby increasing their level of independence.

5. Risk Management

5.1. There are no risks associated with the course of action being proposed in this report.

6. Financial implications

6.1 There are no financial implications associated with the course of action being proposed in this report.

7. Legal implications

7.1. Adequate, fair and meaningful public consultation must be carried out in a compliant manner ensuring that sufficient information is put forward about proposals to change existing services and appropriate time is given for consideration and response. This will ensure that any future decisions made around service remodelling, are lawful.

8. Property implications

8.1. There are no direct property implications for the Council.

9. Health and wellbeing implications

9.1. The Council has a statutory duty to promote the health and wellbeing of its population. Inappropriately prolonged stays in hospital can have a detrimental effect on an individual's health and well-being. It is also evidenced that assessments to determine the long term health and social needs of an individual conducted in a hospital setting tend to be more risk averse and lead to

inappropriately higher levels of provision, which can create dependency and further impact on an individual's health and well-being.

9.2. A model of 'Discharge to Assess' facilitates a timely discharge thus reducing the tendency for an older patient to 'decondition' (i.e. be at risk of increased dependence) and for assessments to be conducted to determine long term need outside of the acute hospital setting, thereby producing a more appropriate assessment of need for social care involvement.

10. Staffing implications

10.1 No staffing implications have been identified as staff within all the services which are the subject of this report are employed within the external/independent sector.

11. Equality implications

11.1 An equality impact assessment has been undertaken and attached as Appendix B to this report.

12. Consultation

12.1 There was an exit interview of individual patients who are discharged from the discharge to assess beds and the feedback has been mixed. Some families have reported how they have found the arrangements excellent and others have reported that they were readmitted to hospital and so should not have been discharged, with a range of experience in between these which, along with feedback from further consultation for which this report seeks approval, will be taken into consideration in the remodelling of the service provision.

Background papers
Commissioning Winter Capacity 2014/2015 Cabinet report – 29th October, 2014
Joint Capacity Plan for Winter 2014/2015?

[Appendix A – Urgent Care Performance Recovery Plan]
[Appendix B – Equality Impact Assessment]

Author

Kerrie Allward
Head of Integrated Commissioning Adult Social Care
☎ 654713
✉ kerrie.allward@walsall.gov.uk

Keith Skerman
Interim Executive Director

Date 21.04.2016

Councillor Hughes
Portfolio holder

Date 21.04.2016

Walsall SRG

Urgent Care Performance Recovery Plan

March 2016

Draft 2 (11/3/16)

1. Executive Summary

This document sets out the recovery plan for the urgent and emergency care system in Walsall. The current system consistently fails to deliver the national standard that 95% of patients attending A&E wait a maximum of four hours. The plan aims to improve performance to above England average (92%) by June 2016 and to 95% by October 2016.

The plan contains the following sections:

- Diagnosis of system challenges
- Key interventions
- Risks and mitigations
- Governance arrangements
- Trajectory for recovery

We have listened carefully to feedback during the development of this plan and have incorporated additional intelligence from ECIP to ensure we have properly diagnosed the causes of poor performance. We have triangulated our findings with other independent sources (e.g. the recent CQC inspection of Walsall Healthcare NHS Trust, an earlier review by Ian Sturgess and an ECIST length of stay review) and drawn on national best practice to identify interventions which will have the most impact on quality, safety and performance. In particular, we have considered the 8 High Impact Changes for emergency care (NHS England, April 2015) to maximise the impact and effectiveness of each intervention and assessed the risks and how to mitigate them.

We have considered the governance arrangements necessary to maintain focus and accountability for delivery of our plan, starting with the joint agreement of the leaders of the Walsall health and social care economy that the plan's diagnosis and interventions are right.

In setting the trajectory for recovery of the 95% A&E standard, we have struck a balance between the imperative to improve performance as rapidly as possible while acknowledging the deep-rooted nature of some of the constraints and challenges facing our system. There is, however, system-wide commitment to both recovering performance and sustaining improvement for the long-term.

The causes of poor performance and the interventions planned to address them are:

Challenge 1 – Demand Management	Interventions
• Rising numbers of emergency admissions • Rising numbers of ambulance conveyances to hospital • Disorganised systems in for streaming and triage in the Emergency Department	• Give paramedics direct access to GP advice / rapid response at incident • Support care homes • Assess / treat therapy needs in hospital promptly • Improve Frail Elderly Service • Improve pathways between ED and Urgent Care Centre and improve ED processes

Challenge 2 – Hospital Flow	Interventions
• Inconsistent ward processes • Reduced discharges over weekend	• Implement 'SAFER' bundle • Enhance weekend working

Challenge 3 – Discharge	Interventions
• High numbers of 'medically fit for discharge' (MFFD) patients • 'Discharge to Assess' model too bed-based • Lack of alternative provision for complex patients, particularly those with dementia	• Case manage MFFD patients with length of stay > 14 days in line with Delayed Transfers Of Care (DTOC) guidance • Enhance flow through Swift Ward * • Change Discharge to Assess model • Develop a discharge and flow pathway for patients with dementia

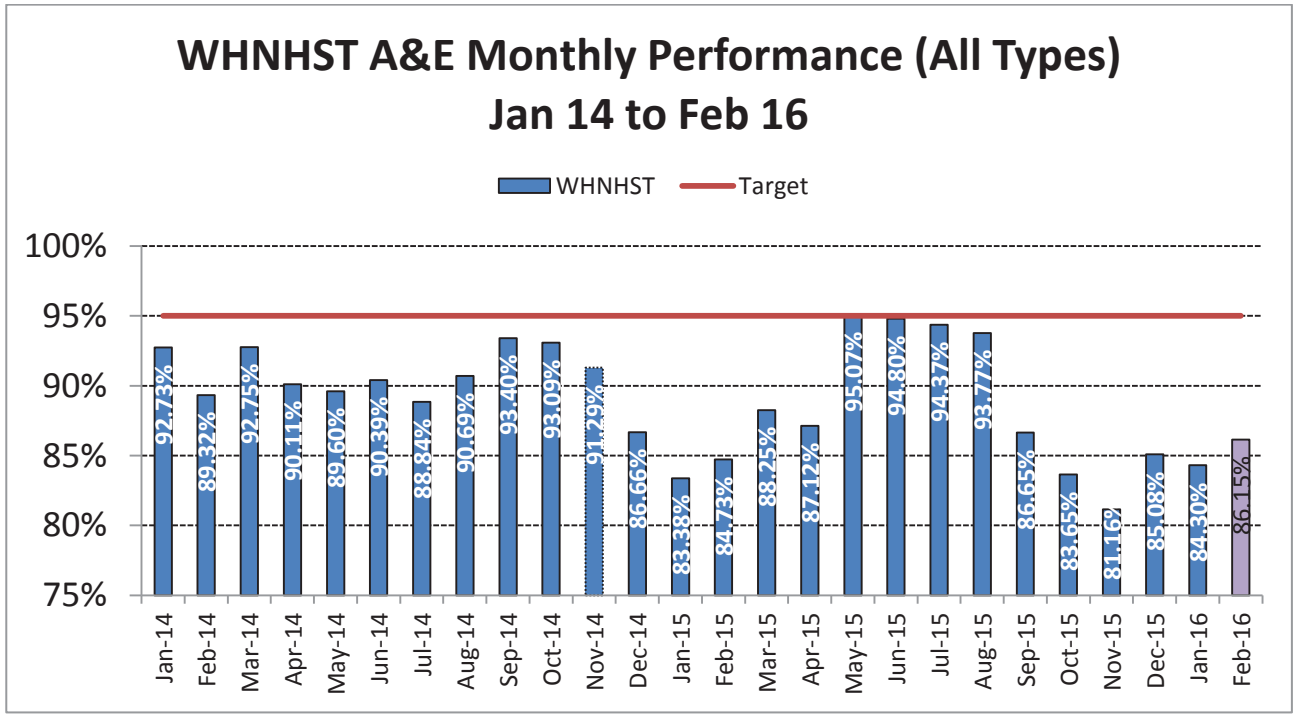
*Swift Ward is a 32-bedded ward at Walsall Healthcare Trust caring for frail elderly patients who are medically fit for discharge but have complex post-acute needs.

2. Introduction

Walsall's urgent care system consistently fails to deliver the NHS constitutional standard that 95% of patients attending A&E wait a maximum of four hours from arrival to admission, transfer or discharge. A recovery in performance between May and August 2015 (ranging from 93.8% to 95.1%) has not been sustained and monthly performance subsequently dipped to between 81.2% and 86.7% during September 2015 – February 2016.

Monthly performance since January 2014 is illustrated below:

Chart 1



We recognise that the A&E 4 hour standard is a barometer, not only of the quality of care and experience of patients using Accident and Emergency services, but is symptomatic of the effectiveness of the entire urgent care system. Our current system is fragile and not well equipped to sustain good performance.

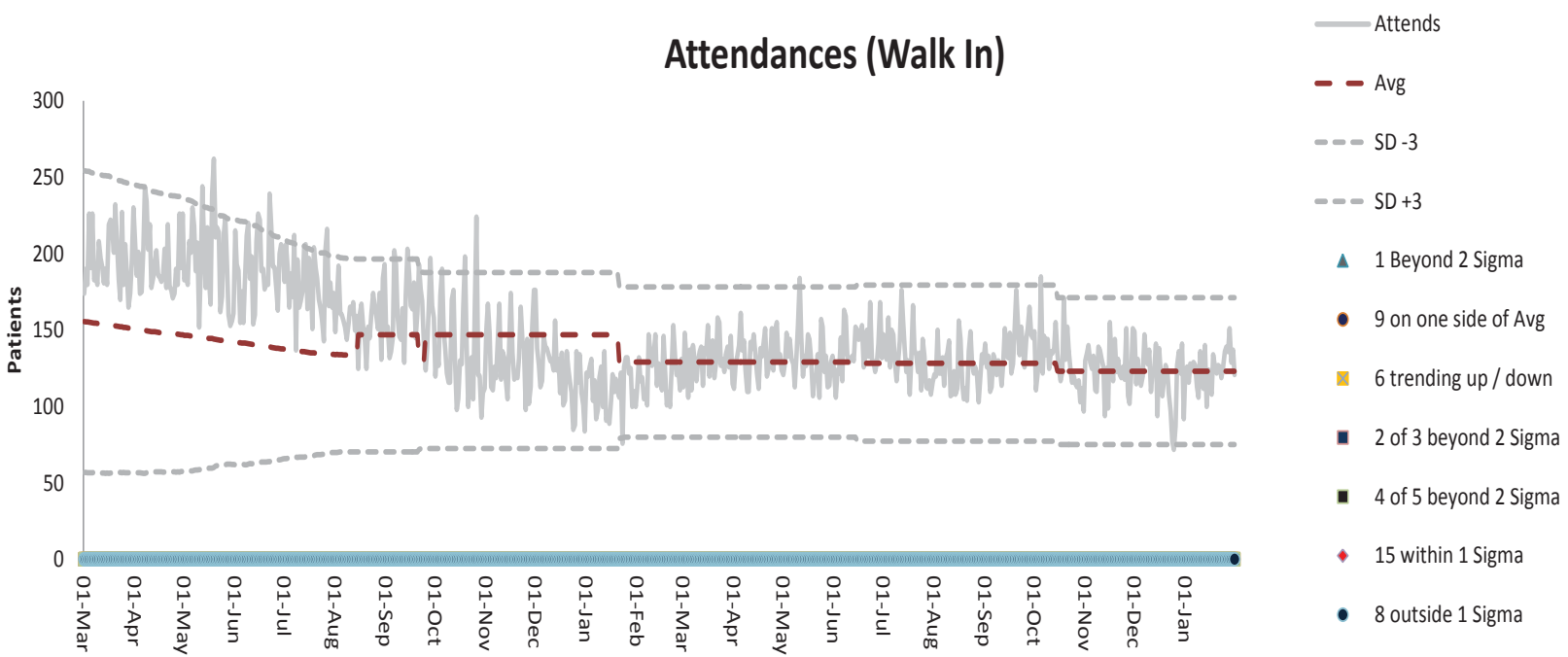
3. Diagnosis of System Challenges

i. Demand Management

ED Attendances

Looking at demand into the Emergency department, we can see that overall type 1 attendances have decreased by -4.2% from August 2014 to January 2015 compared with the same period in 2015/16 (40,417 to 38,720). However, whilst ambulance attendances have increased in the aforementioned time period (+1.7%; 15,138 to 15,391), walk in attendances have significantly decreased by -7.7% (25,729 to 23,339) see graph below. The reduction in type 1 attendances is mainly due to changes in the way the Urgent Care Centre operated in this period.

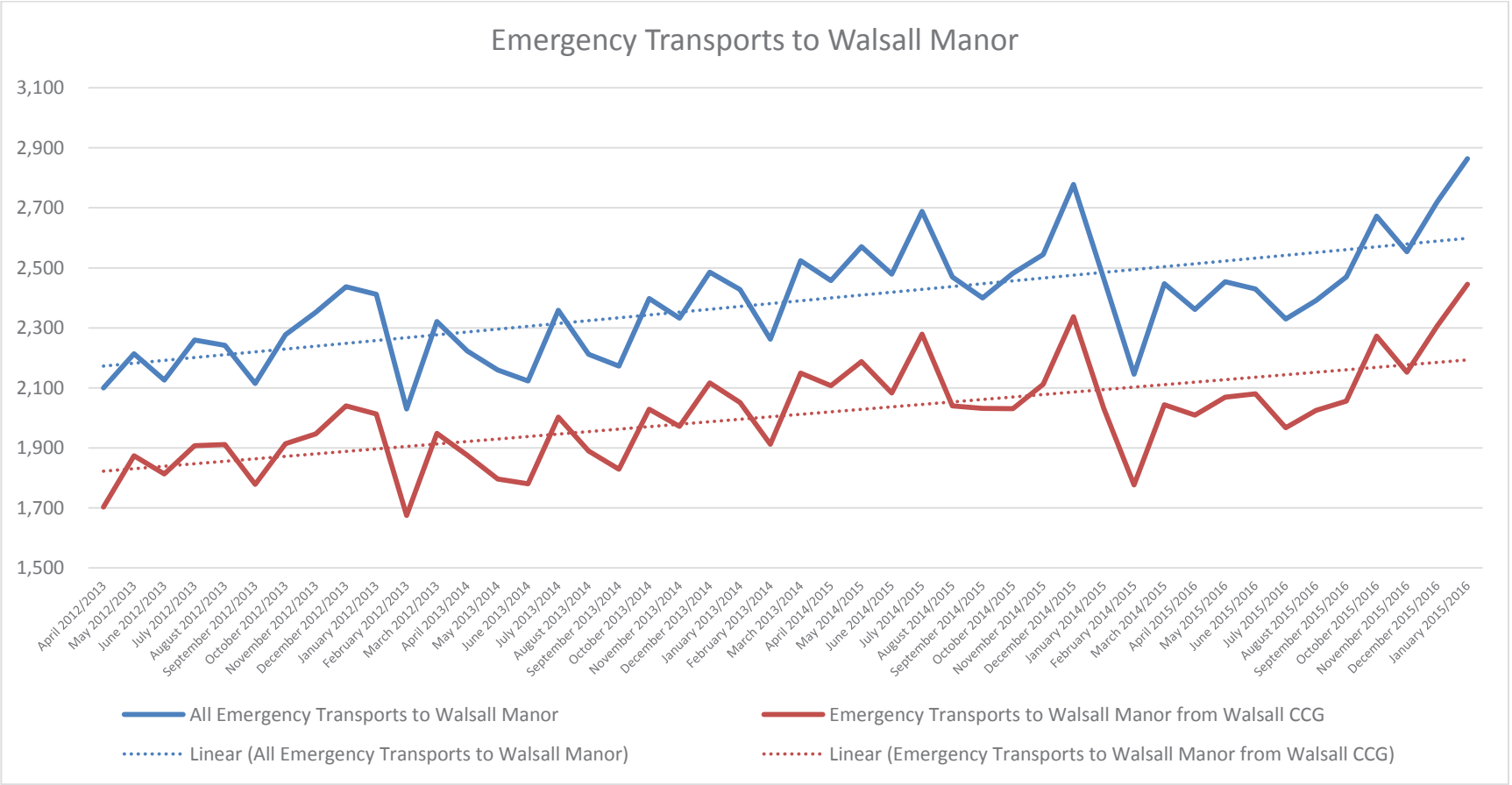
Chart 2



Ambulance Conveyances

Chart 3 illustrates a steady trend of increasing ambulance conveyances to Walsall Manor Hospital overall, with no change in the proportion originating in Walsall vs outside of Walsall. The volume of transports in the six months August 15 – January 16 is 2.9% higher than the equivalent period last year, reaching a new high in January 2016.

Chart 3



Charts 4 & 5 illustrate the postal areas with the highest volumes of ambulance conveyances comparing a six month period in 14/15 with 15/16. These patterns are stable with no evidence of disproportionate growth of ambulance conveyances from outside the WS postcode catchment area. Demand management activities for ambulance conveyance therefore need to focus within the borough rather than outside.

Chart 6 suggests demand for ambulance transports is being driven by self-referral rather than GP referral.

Chart 4

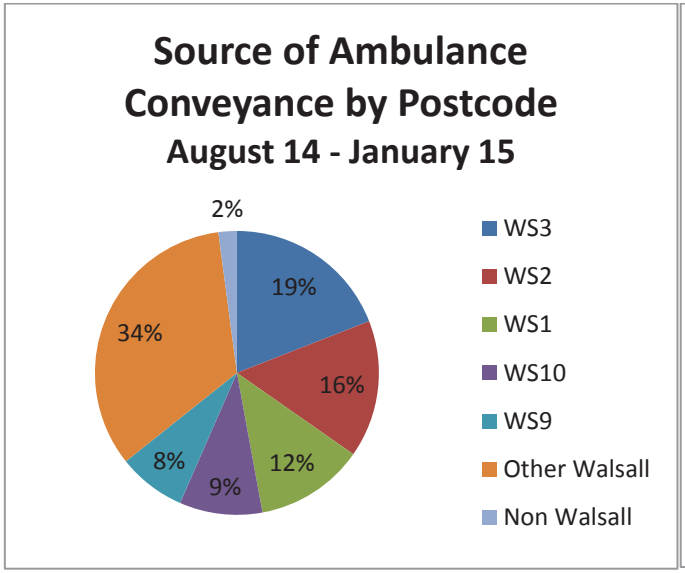


Chart 5

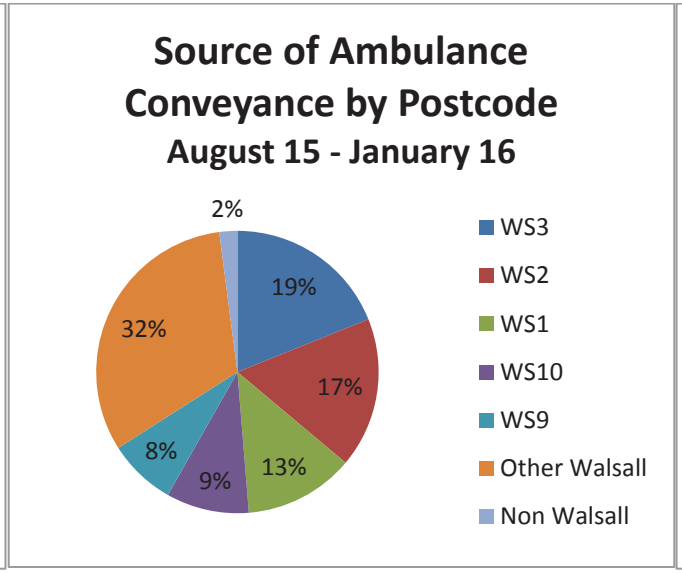
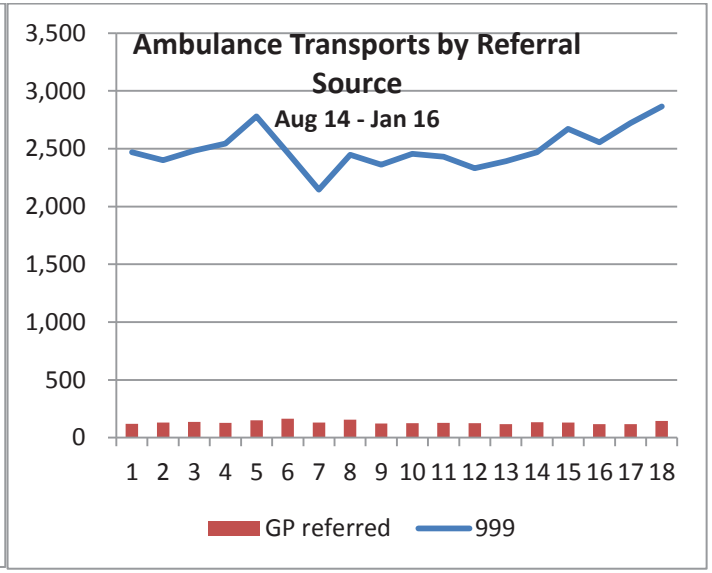


Chart 6



Ambulance Conveyance vs Admissions

The conversion rate of ambulance conveyance to admission has remained stable at an average of 48% but still places additional demand on ED. While this increase is partly explained by a seasonal trend observed over winter with an increased acuity of patients, Walsall is one of only two systems in the West Midlands (the other being Wolverhampton) which has seen this high level of activity. (Charts 7 & 8).

Chart 7

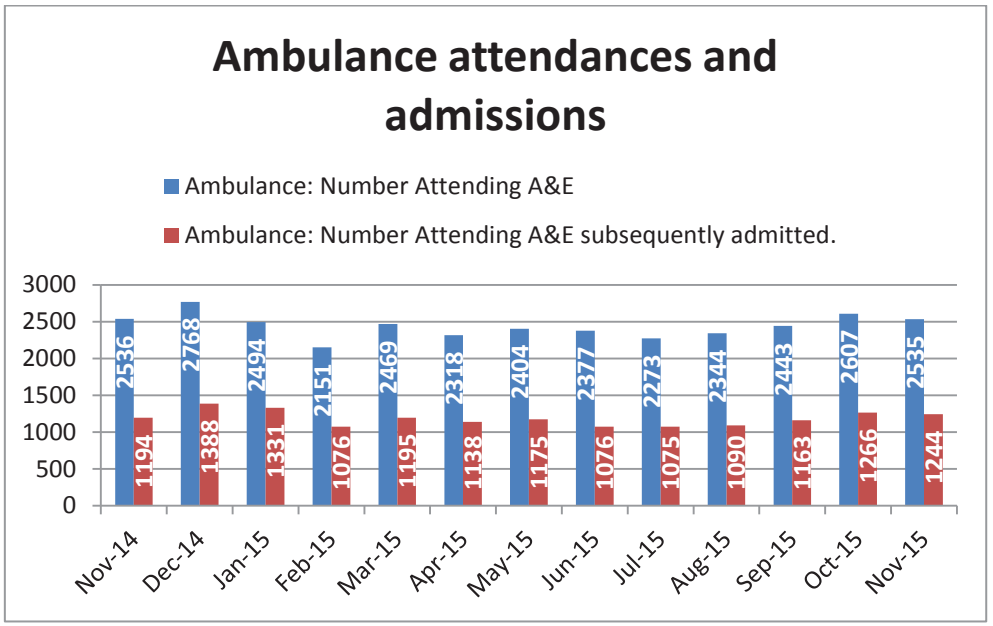
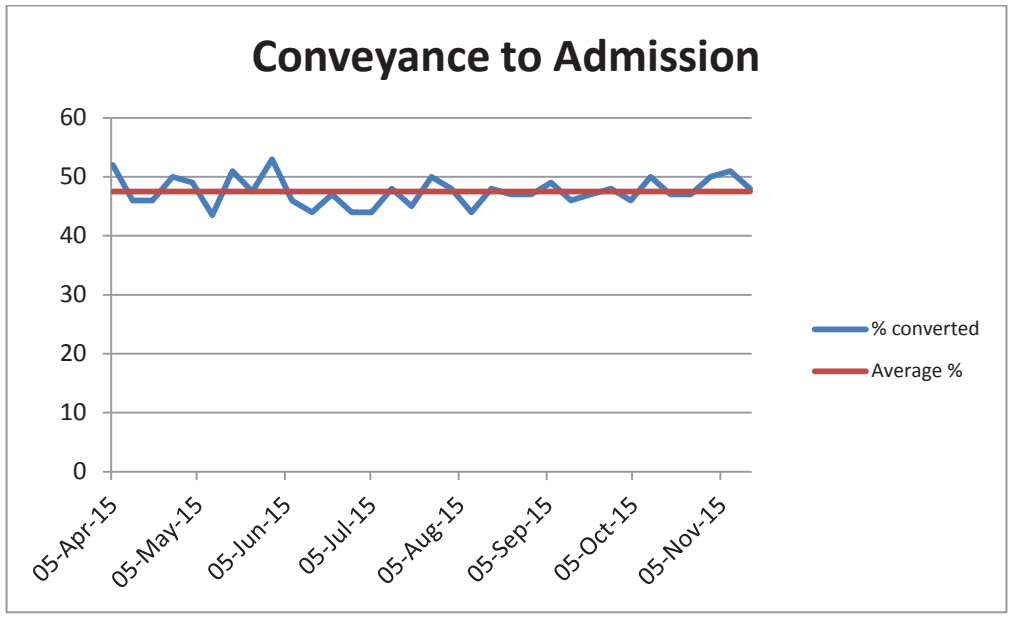


Chart 8



Emergency Admissions

Emergency admissions – There has been a circa 4% increase in emergency admissions during 2015 compared to 2014. The conversion rate of ED attendances to emergency admissions was 25% in 2014, 26% over the summer 2015 and rose to 30% - 33% from September to December 2015.

Chart 9

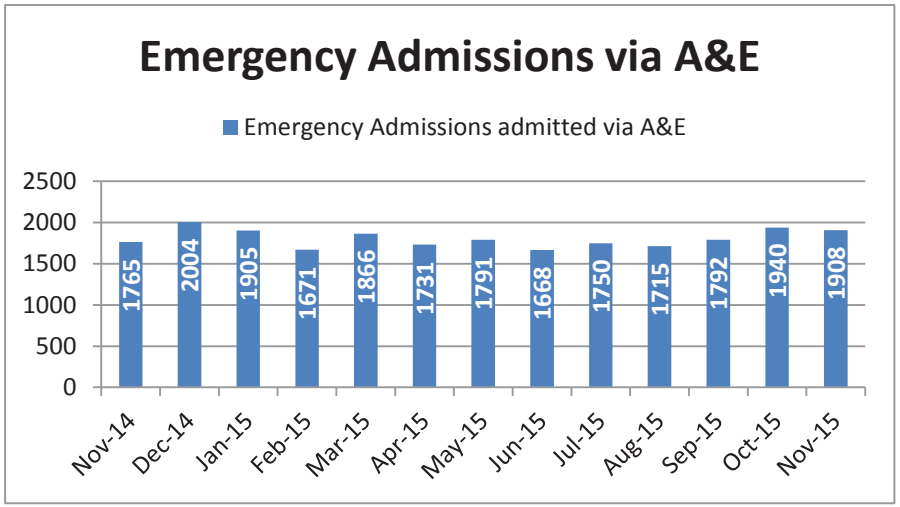


Chart 10

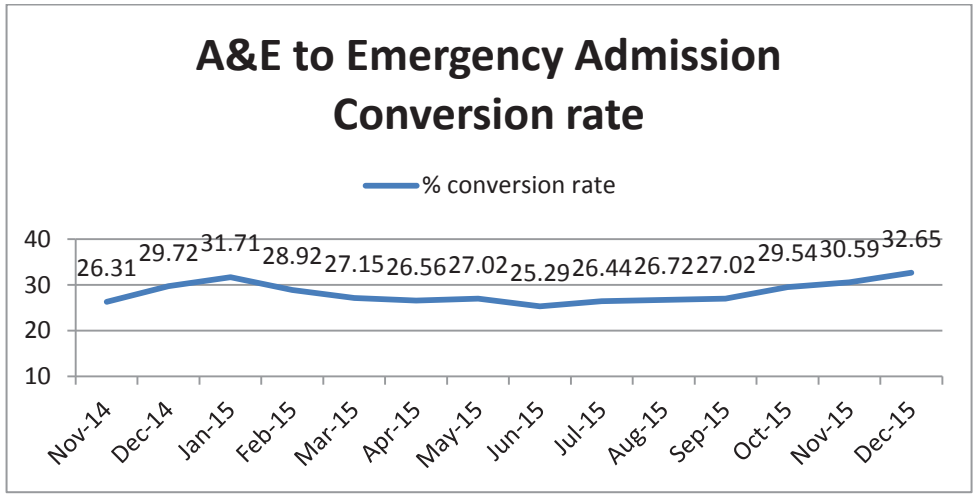


Table 1 illustrates that the most significant percentage increase in emergency admissions has been in the younger adult / children's age category. While this demand does not contribute to occupied bed days nor 4 hour breaches to the same extent as older peoples' admissions, there is scope to identify admission avoidance measures for children, adolescents and younger adults.

Table 1 **Change in Emergency Admissions by Age Band, January - December 2015**

Age Band	Admissions	Admissions change on last year	Age band % of admissions	Registered practice population*	Age band % of population	Admissions per 1,000 population
0 - 24	6,216	9%	20%	88,572	32%	70.2
25 - 49	7,742	8%	25%	92,328	33%	83.9
50 - 74	9,039	6%	29%	73,830	27%	122.4
75+	8,481	-1%	27%	22,375	8%	379.0
	31,478	5%		277,105		113.6

Interface Between Emergency Department and Urgent Care Centre

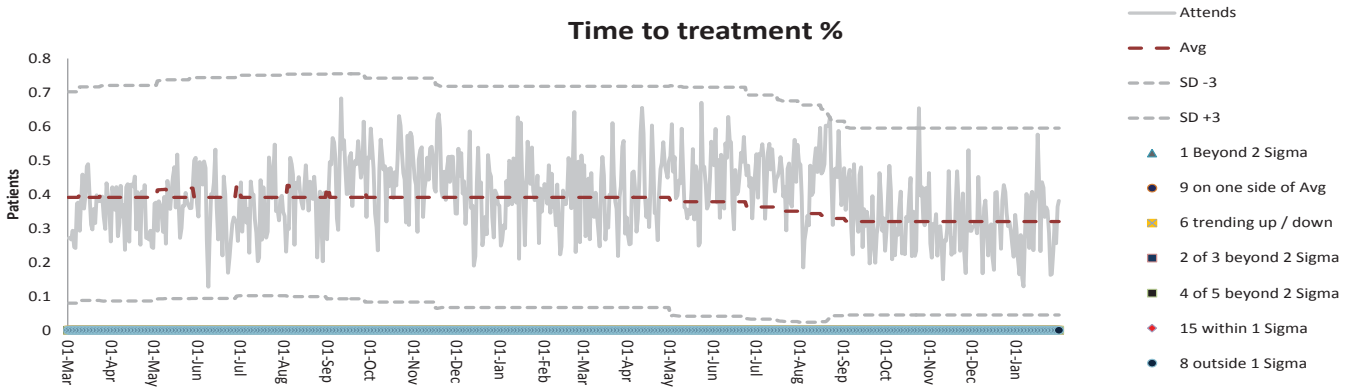
A newly procured Urgent Care Centre (UCC) was mobilised in October 2015, located on the Walsall Manor Hospital site, operated by Primecare. There are a number of interface issues between the ED and UCC including:

a) Confused streaming and triage systems which sometimes direct patients inappropriately to ED instead of UCC and vice versa.
b) Inadequate clinical triage processes.
c) Constraints in accessing pathways / services for patients out of UCC, resulting in unnecessary redirection to ED.
d) Obstacles to accessing diagnostic test results in UCC.
e) Bottlenecks and lack of space in ED compounded by channelling of UCC patients to same environment for streaming / triage.
f) Minor injuries patients continuing to present at ED due to workforce constraints in UCC.

Processes within ED

The performance around the 'time to treatment' metric (time from arrival to seen by a clinical decision maker) has historically been low at around 40% of patients seen within 60 minutes of arrival. The national average is approximately 55%. This is a close marker for performance against the A&E 4 hour wait time standard. However, what we can see from the time series graph below (Chart 11) is that there is significant variation in this metric. We can also see, that over the past 4 months, the performance around this has deteriorated, coinciding with the decline in the 4 hour standard.

Chart 11



Conclusions – Demand Management

- **Rising numbers of emergency admissions (including among children, adolescents and young adults)**
- **Rising numbers of ambulance conveyances (generated within Walsall rather than extra demand from outside)**
- **Disorganised systems in Emergency Department and problematic interface with the Urgent Care Centre**

ii. Hospital Flow

Ambulatory Care

Analysis on the proportion of patients staying 0 days (often referred to as ambulatory) is low compared with the National profile of 30%, at circa 20% (see chart 12 below). This is also mirrored in the proportion of patients staying between 0-2 days (short stay / assessment patients) – Chart 13. Performance in this area is around 50%, whereas the National profile around this area is between 65-70%. A greater use of ambulatory care capacity might improve flow from ED.

Chart 12

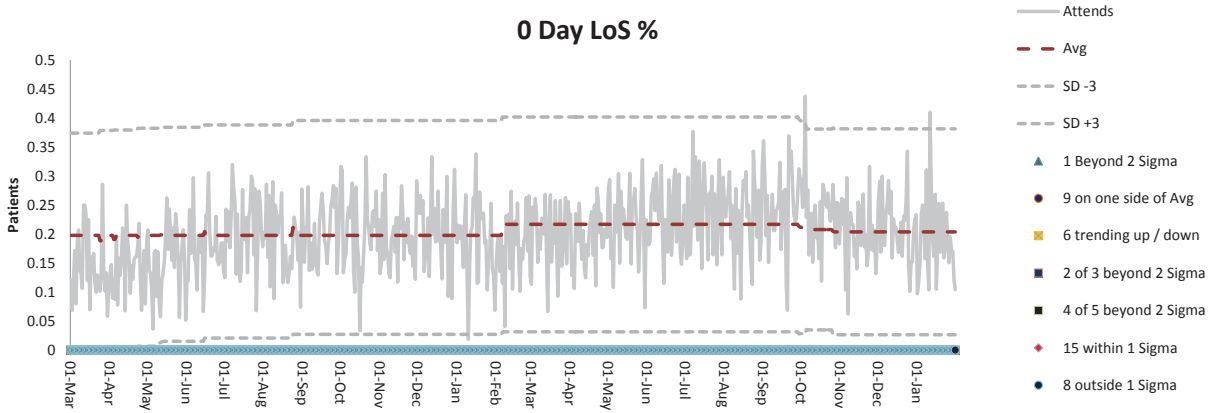
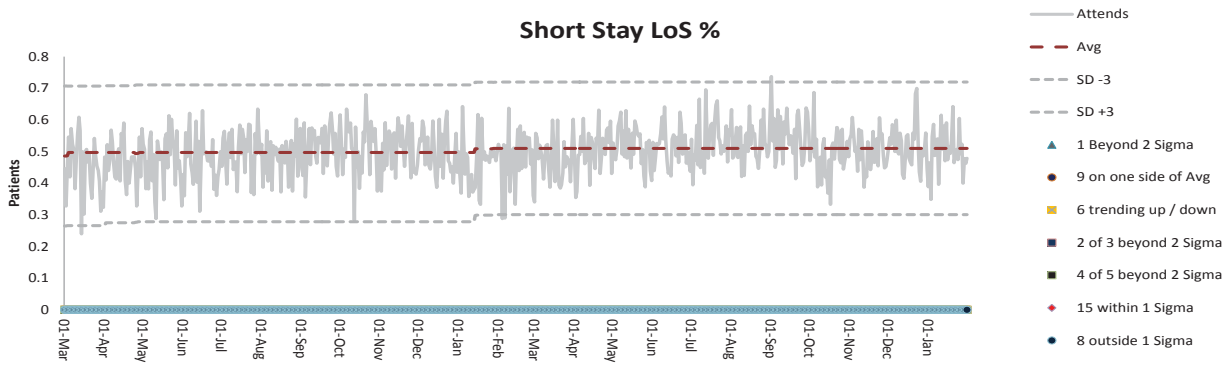


Chart 13



Imbalance of Admissions and Discharges

Analysing discharge profile for the period August 15 – January 16, both time of day and day of week, we can see (from charts 14 and 15 below) some interesting patterns. Discharges by time of the day, with a peak at 6pm and continuing into the mid-evening are more delayed than we would expect. ECIP have told us that, nationally, peak discharges occur at 3pm.

Chart 14 below shows that discharges are heavily weighted to a Friday (peak at 80) compared with Saturday (45) and a low on Sunday of 40. It is also interesting to see that discharges are high on a Tuesday. ECIP have told us this is not seen in other organisations. This variation impacts on flow of patients through the emergency floor over the weekend and also impacts negatively on patient outcome, with patients admitted over the weekend having 1 day longer LoS than patients admitted on a Monday.

Chart 14

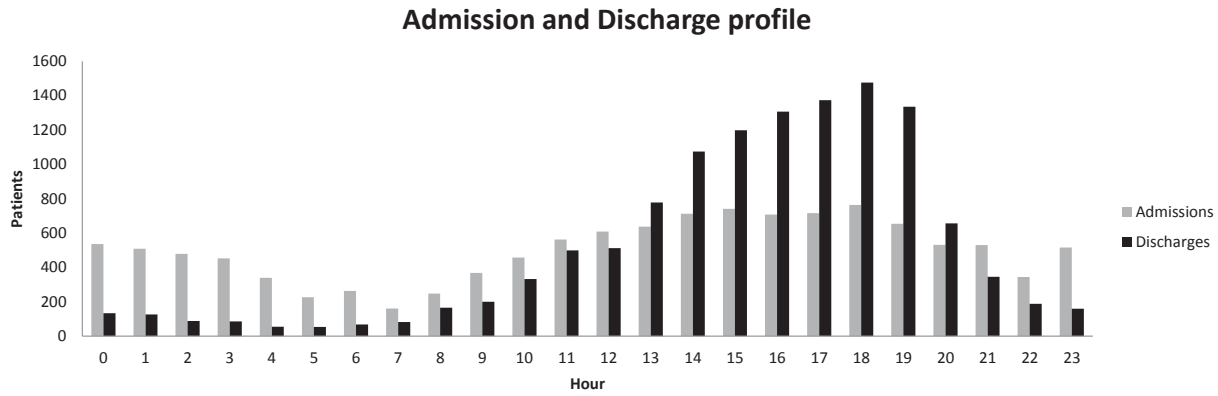
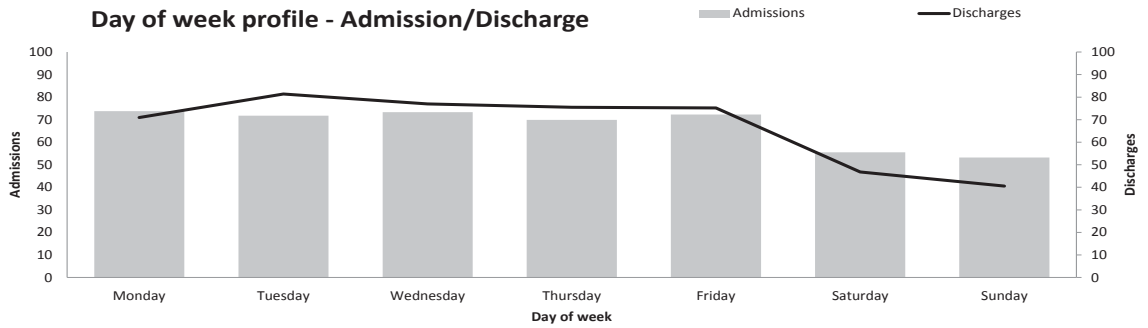
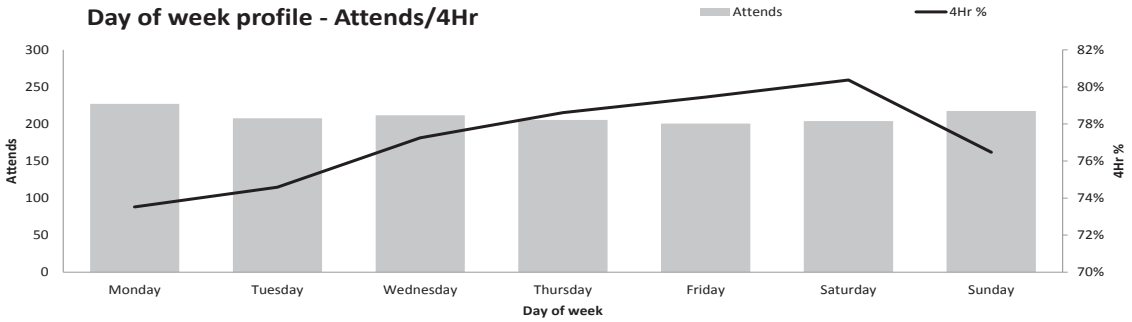


Chart 15



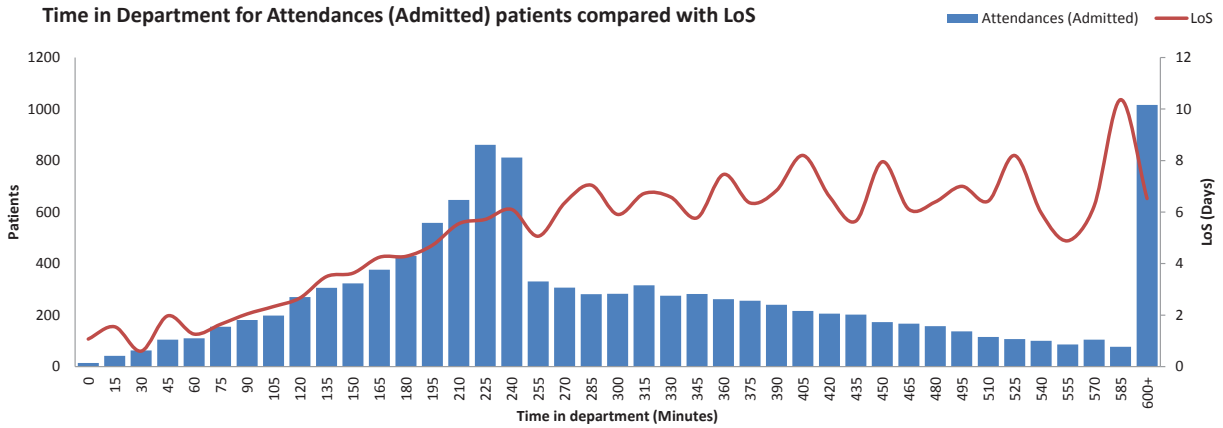
We can see, from the attendances / 4 hour performance by day of week graph below (chart 16), that the above disparity between admissions and discharges has an impact on the variation in performance. With a reduction in discharges over the week contributing to an increased bed occupancy and reduction in patient flow through the emergency pathway.

Chart 16



We can see from the graph below (chart 17) that the longer the patient's time in ED, the longer their length of stay in Hospital. Summarising this, if a patient is admitted within 4 hours of attendance time the average length of stay is 4.1 days. However, if they breach the 4 hour standard and are admitted the length of stay increases to 6.5. While there may be several factors affecting this (e.g. more poorly waiting for admission to a bed, poor flow affecting both figures) it indicates a potential link between length of stay in ED and eventual overall length of stay.

Chart 17



Other factors affecting hospital flow include:

- Lack of capacity when needed in the Acute Medical Assessment Unit (AMU), which is intended as the receiving ward for both acute GP referrals and patients in ED requiring medical assessment. The inability to clear these beds systematically throughout the day can result in the Unit being full and patients backing up in ED.

- Variation between inpatient wards in the setting of Expected Dates of Discharge (EDD) and the proportion of discharges occuring in the morning. This reduces bed availability at times when patients need to be pulled through from AMU.

- A reduction in the availability of some services over the weekend (e.g. therapies) and the availability of senior clinical review of patients.

Conclusions – Hospital Flow

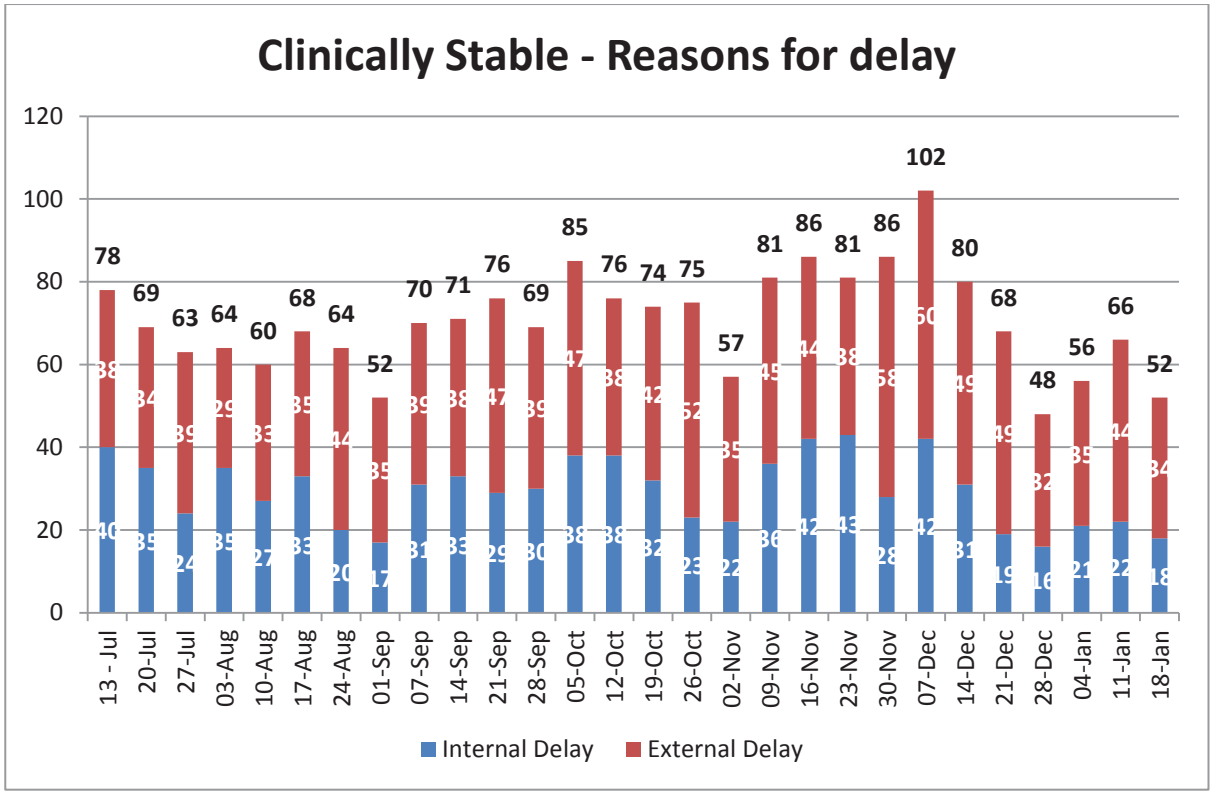
- **Sub-optimal utilisation of and processes within Acute Medical Assessment, Ambulatory Care and short stay wards**
- **Inconsistent ward processes to promote flow**
- **Reduced discharges over the weekend.**

iii. Discharge processes

Medically fit for discharge

Walsall, like many health economies, has significant numbers of patients who are medically fit for discharge but who remain in an acute hospital bed, sometimes for many weeks (Chart 18).

Chart 18



The good progress that was made in the run up to Christmas to reduce these numbers has been sustained but concerted effort will be required to drive the numbers lower, particularly those who remain in hospital longer than 14 days (and ultimately 7 days) after being declared medically fit for discharge.

Discharge to Assess

Through the Better Care Fund, Walsall health and social care has invested £1.56m in 40 discharge to assess beds in nursing homes. The beds were commissioned to facilitate the discharge of patients whose acute phase of care was complete, for a maximum of 6 weeks, to enable the assessment of their ongoing care needs and put appropriate packages of care in place. Meanwhile, their therapeutic needs would continue to be provided. The experience of these beds has revealed some areas of weakness that need addressing, including:

- an absence of explicit GP medical cover, which if a patient's clinical condition has deteriortaed, has on occasions resulted in readmission to WHT.
- an imbalance of the use of beds which are overwhelmingly used as step-down beds from hospital, while step-up options also need attention
- a tendency for patients with poor long-term outcomes to be discharged to bed-based care when, with appropriate support, discharge home is a better option.
- too many people with dementia being discharged directly to care homes resulting in fewer returning to their usual place of residence
- the lack of a fully developed discharge to assess model in that admission to the beds still requires hospital-based assessment

We have an opportunity to re-commission the Discharge to Assess model to halve the number of beds and re-invest resources in additional home re-ablement capacity and enhance specialist support to both bed-based and community services, with a particular emphasis on developing a supportive and responsive provision for people with dementia.

Complex Discharges

Swift Ward (32 beds) in WHT has been the facility that accommodates patients who are medically fit for discharge but who have complex health and social care needs. These patients experience the longest length of stay and account for a significant proportion of hospital bed capacity that is consequently unavailable to support acute care. As part of winter resilience funding, extra investment in community home-based reablement and social worker input has successfully increased the turnover of patients through Swift and reduced average length of stay, however, these solutions are non-recurrent and due to end soon. The system needs to sustain the interventions which have proven to be effective.

4. Key Interventions

We have identified **ten** interventions, aligned to our diagnosis, to improve system performance and recover achievement of the 95% A&E standard. Of these, **seven** (in red below) are linked to short-term recovery and will therefore be the focus of our immediate attention. Action 10 is equally important due to its interdependence with other actions and contribution to longer-term sustainability.

Demand Management

- **Action 1**: Increase ambulance diversion via direct access for paramedics to patient GP at point of incident and enhanced access to Rapid Response Service.
- **Action 2:** Support care homes to prevent necessity for residents being conveyed to hospital unnecessarily.
- **Action 3:** Conduct therapy assessments in ED or within 24 hours of admission aligned with therapy support for discharge to assess at home.
- **Action 4:** Complete implementation of Frail Elderly Service (with social care and mental health input).
- **Action 5:** Improved senior clinical decision making in ED –improved ED pathways including between UCC and ED.

Hospital Flow

- **Action 6:** Complete Implementation of the 'SAFER' bundle consistently across all wards (**S**enior review, **A**ll patients have an expected date of discharge, **F**low early from assessment units, **E**arlier discharge, **R**eview long length of stay patients).
- **Action 7:** Enhance weekend focus on discharge, review senior rostering.

Discharge

- **Action 8:** Implement individual case management of patients on MFFD longer than 14 days, aligned to DTOC guidance.
- **Action 9:** Continue enhanced flow management in Swift Ward.
- **Action 10.** Halve the number of DtA beds in nursing homes (from 40 to 20) and transfer funding to additional social care reablement capacity to support home-based DtA mode and enhance specialist support, particularly for those with dementia.

Action 1: Reduce Ambulance Conveyance to Hospital

Owner: Andy Rust (CCG Urgent Care Lead), Anand Rischie (Urgent Care Governing Body Lead GP)

Problem to be solved:	Actions:	Progress:
Increasing numbers of self-referred 999 calls to ambulance services and conveyances to hospital	• *Ensure WMAS Paramedics have direct access to patient practice at point of incident* • *Ensure WMAS Parameds have direct access to Rapid Response Service at point of incident* • *Ensure Rapid Response Service has rapid access to social care reablement for follow up support*	• *Confirmed telephone numbers for direct access to patient practice and Rapid Response Service is in place.* • *LMC and GP Locality meetings briefed* Review: • *Monitor WMAS usage of these communications as a means of avoiding conveyance*
Intervention: *Give paramedics direct access to patient GP at point of incident and enhanced access to Rapid Response Service*	Impact: *2% reduction in ambulance conveyances from baseline of April 15 – March 16 (-2 ambulances per day)*	Risks: • *Variable response across primary care* • *Variable take up of these options by WMAS paramedic crews* • *Maximum capacity of rapid response service is a constraint* • *Maximum capacity of social care reablement is a constraint*
Rationale: *Improved contact with patient's GP Practice and / or rapid response service at point of incident will reduce conveyances*	Due Dates: *Implementation: March 2016* *Outcome Impact: June 2016*	Mitigation: • *Continue campaigning for GP support* • *Training and Development for WMAS paramed crews – ease of information to increase access* • *Increase capacity of rapid response* • *Increase capacity of social care reablement*

Action 2: Improve Coverage of End of Life Support for Nursing Homes

Owner: Andy Rust (CCG Urgent Care Lead, Yvonne Higgins (CCG Head of Quality & Safety)

Problem to be solved:	Actions:	Progress:
Unnecessary transfers of End of Life patients to ED from care homes. (More significant from out of area care homes) **DECISION FOR SRG WHETHER TO REMOVE THIS ACTION DUE TO** - **INSIGNIFICANT IMPACT ON DEMAND** - **SYMPTOM OF POOR DISCHARGE PLANNING (NOT CARE HOME SUPPORT) – THEREFORE ADDRESSED ELSEWHERE IN PLAN**	• *Community Nurse Teams are providing wrap around support to care homes in the form of comprehensive holistic assessment of residents at high risk of admission to hospital; develop a personalised written management plan; and case co-ordination. Written management plans are in the form of an Emergency Passport.* • *Enhanced GP medical support model* • *Additional support for End-of-Life Pathways piloted in one care home and rolled out*	• *Additional support to care homes via Community Matrons and GP medical support has already had a significant impact on reducing transfers to ED.* • *Pilot for EoL pathway complete and will be rolled out on schedule*. Review: • *Marginal additional benefit likely*
Intervention: *Increase support to care homes.*	Impact: *0.1% reduction in ambulance conveyances from baseline April 15 – March 16*	Risks: • *CQC registration requirements lead to higher incidence of transfer of residents at EoL to ED* • *Family / relatives and care home staff believe hospital is a more appropriate setting for EoL* • *Patient choice of place to die*
Rationale: *Inappropriate for patients on an end of life pathway to be admitted as an emergency to hospital.*	Due Dates: *Implementation: March 2016* *Outcome impact: June 2016*	Mitigation: • *Publicity campaign to challenge perception that hospital is more appropriate place for EoL.* • *Training for care home staff on EoL pathway support and patient choice of place to die*

Action 3: Introduce Therapy Services Earlier in Patient Pathway

Owner: Graeme Johnstone (WHT Head of Therapies)

Problem to be solved:	Actions:	Progress:
'Waiting for Therapy Assessment' a significant proportion of reason for delay of patients on medically fit for discharge list. *Length of stay for stroke patients comparatively long (include evidence)*	• *Implement 7 day working* • *Integrate rotational working between community and acute* • *Change referral pathway from wards to support earlier discharge*	• *Recruitment underway,* Review: • *ECIP have advised to rebalance model of hospital-based therapy assessment to enhance community and front end capacity. The next level of integration would be with social care. What impact would this have?*
Intervention: *Implement changes to Therapy Services to ensure timely assessment and treatment*	Impact: *Reduce average length of stay for Medically Fit for Discharge patients by 0.25 days from March 16 baseline.* *Reduce average length of stay for stroke patients from x to y days – equivalent to z occupied bed days*	Risks: • *Significant cultural and clinical practice change needed* • *Agreement to integration of therapy between WHT, DWMHT and Council* • *Role of therapists in MDT settings needs further clarification.*
Rationale: *'Right place right time' principle for therapy interventions in context of limited capacity is critical to success of intermediate care / social care reablement*	Due Dates: *Implementation: June 2016* *Outcome Impact: August 2016*	Mitigation: • *Agreement to specific work-stream as part of System Transformation* • *Conduct further work on potential impact of revised models based on integration*

Action 4: Mobilise Comprehensive Frail Elderly Service

Owner: Steven Vaughan (WHT Interim Chief Operating Officer)

Problem to be solved:	Actions:	Progress:
Significant numbers of frail elderly people being admitted to hospital beds from ED or MAU when evidence from elsewhere shows that they can be supported to return to their own home ,	*Phase 1* • *Implement multi-disciplinary assessment service in ED led by Consultant Geriatrician* • *Rotational working by Rapid Response practitioners* • *Beds in Ward 29* *Phase 2* • *Social care and mental health as part of MDT* *Phase 3* • *Mobile Working*	• *Phase 1 implementation complete* • *Phase 2 with social care and mental health dependent upon timescale for Action 10* • *Phase 3 mobile working outstanding due to shortage of resource for IT* Review: • *Can phases 2 and 3 be accelerated?*
Intervention:	Impact:	Risks:
A multi-disciplinary frail older people's assessment service at the hospital front door to assess older people and provide a package of support at home to avoid re-admission. Use Ward 29 for overnight bed-based care/assessment where necessary.	*600 fewer frail elderly admissions per annum from April 15 – March 16 baseline.*	• *Social care and mental health input to MDT dependent upon timescale for Action 10* • *Implementing mobile working dependent upon resources to cover cost of mobile technology and digital platform for sharing patient record*
Rationale:	Due Dates:	Mitigation:
Once admitted it is often difficult to discharge in a timely manner due to complexity and there is deterioration in health	*Implementation: March 2016* *Outcome impact: June 2016*	• *Council to assign specific procurement capacity to complete Action 10 in timescale* • *Integrated approach to dementia* • *Seek external funding for investment in mobile working technology and assistance for open API (Application Programme Interface) implementation.*

Action 5: Improve Processes within Emergency Department

Owner: Steven Vaughan (WHT Interim Chief Operating Officer)

Problem to be solved:	Actions:	Progress:
Disorganised systems in ED and problematic interface with Urgent Care Centre	• *Improve communication and sign posting in ED includes UCC* • *Provide real time activity data to ED Team* • *Improve Ambulance handover* • *Review and revise streaming, triage and referral pathways (e.g. FES) includes UCC* • *Extend senior clinical staff presence to 10.00pm* • *Agree escalation process for high demand* • *Review current model of pathways between ED-AMU-Wards* • *Implement short stay ward*	• *All actions underway and aligned with response to CQC report. Actions updated regularly and RAG-rated. Joint agreement of actions to improve triage and referrals between UCC provider and WHT ED.* Review: • *Constant process of review, implement change, review and implement next iteration*
Intervention:	Impact:	Risks:
Enhance availability of senior clinical decision making in ED. *Clarify referral pathways from ED to assessment areas / wards.* *Improve interface between UCC provider and ED*	*From a baseline of April 15 – March 16:* *Reduction bed related breaches by 10 per day* *Reduction in cross referrals by 10 per week* *Reduction in ambulance handover delays by 50%*	• *Availability of senior clinicians for extended hours in ED* • *Poor joint working between UCC provider and A&E in ED* • *Availability of beds for short stay /*
Rationale:	Due Dates:	Mitigation:
Improve patient experience in ED. Improve triage and referral to exit pathways. Optimise capacity.	*Implementation: March 2016* *Outcome impact: August 2016*	• *Engagement with senior clinicians* • *Continue enhanced joint working between UCC provider and A&E in ED* • *Review Ward 14 for short stay beds* • *Optimise use of available space*

Action 6: Implement SAFER bundle

Owner: Steve Vaughan (WHT Interim Chief Operating Officer), Naj Rashid (WHT Associate Medical Director – MLTC)

Problem to be solved:	Actions:	Progress:
Discharge processes currently vary by ward leading to discharges later in the day and too few discharges at the weekend.	• *Develop revised operational policies for AMU and medical wards covering all aspects of SAFER* • *Confirm implementation timeline* • *Develop Communications Strategy* • *Develop Patient Flow Dashboard to support flow management and process of monitoring and review of implementation of revised operational policy* • *Ensure appropriate level of involvement by social care in SAFER bundle*	*Patient flow Dashboard in place and updated weekly shows admissions and discharges by time of day/week at ward level. Ready to be shared with SRG.* Review: *Constant process of review, implement change, review and implement next iteration*
Intervention: *Implement all aspects of SAFER bundle in line with ECIP guidance.*	Impact: *From a baseline of April 15 –March 15:* *Reduction in breaches by 10 per day* *Increased rate of early discharges by 20%* *Increased rate of week-end discharges by 20%*	Risks: • *Difficulty changing culture and clinical practice* • *Resistance to revising job plans for 7 day working* • *Poor engagement with clinical leadership* • *Ineffective comms and engagement with workforce*
Rationale: *Improve flow management to reduce length of stay, reduce numbers on the medically fit for discharge list and improve patient experience.*	Due Dates: *Implementation: March 2016* *Outcome Impact: August 2016*	Mitigation: • *Sign off revised operational policies and agree timelines at Board level* • *Clarify roles and responsibilities of clinical directors linked to clinical engagement strategy*

		and clinically led structure • *Workforce comms and engagement strategy*

Action 7: Increase Number of Weekend Discharges

Owner: Steven Vaughan (WHT Interim Chief Operating Officer)

Problem to be solved:	Actions:	Progress:
Too few discharges over weekend.	• *Linked to Action 6 SAFER Bundle* • *Implement Manager on-call rota* • *Clarify SAFER senior doctor role process* • *Review role, function and policies supporting 'criteria led' week-end discharges* • *Review current ward round model* • *Ensure appropriate level of involvement by social care in hospital* • *Ensure capacity for week-end discharge in social care domiciliary care market* • *Engage with care homes to accept admissions at week-end* • *Assess impact on wider systems and services*	• *Expected Date of Discharge and DTOC guidance implemented to facilitate planned discharges at weekend.* • *Social care presence in place.* Review: • *Constant process of review, implement change, review and implement next iteration*
Intervention:	Impact:	Risks
Increase the number of weekend discharges.	• *Reduction in breaches on Mondays by 15* • *Increased rate of week-end discharges by 20%*	• *Delay in Implementation of on-call management rota* • *Difficulty changing culture and clinical practice arising from SAFER bundle.* • *Poor engagement with Clinical leadership* • *Ineffective comms and engagement with workforce* • *Care homes not accepting weekend admissions*
Rationale:	Due Dates:	Mitigation:

Increased week-end discharges will maintain consistent flow leading to lower level of escalation on Mondays and smoother flow through the week.	*Implementation: April 2016* *Outcome Impact: September 2016*	• *Complete consultation over on-call rota* • *Workforce communications and engagement strategy* • *CCG engage with care homes over week-end admissions*

Action 8: Reduce the Numbers on Medically Fit for Discharge List

Owner: Steven Vaughan (WHT Interim Chief Operating Officer, Lloyd Brodrick (Walsall Council Group Manager, Integrated Health & Adult Social Care)

Problem to be solved:	Actions:	Progress:
Bed capacity taken up by large numbers of medically fit for discharge patients, contributing to poor patient flow, high numbers of ED breaches due to bed availability and inconsistent discharge planning based on DTOC guidance	• *Daily complex cases panel to review all cases on CS/MFFD list and consistently apply DTOC guidance to patients over 14 days* • *Lower case management threshold from 21 days to 14 days* • *Review and revise to 7 days* • *Implement patient choice policy*	• *14 days achieved. Complex cases panel reviewing down to 7 days at present. Patient choice policy inconsistently applied across hospital.* Review: • *Should the patient choice policy be simplified and re-implemented?Can the process of managing the CS/MFFD list be streamlined as SAFER bundle is implemented?*
Intervention: *Implement individual case management of patients on CS/MFFD list longer than 14 days*	Impact: • *Reduction in number on CS/MFFD by to daily average of 50* • *Reduction in average LoS of patients on CS/MFFD list by 0.5 days from April 15 – March 16 baseline*	Risks • *Implementation of on-call management rota in process of consultation* • *Linked to change in culture and clinical practice arising from SAFER bundle.* • *Engagement with Clinical leadership* • *Communications and engagement with workforce* • *Further work needed with care homes (linked to Action 2)*
Rationale: *Senior review of complex cases and case*	Due Date: *Implementation: March 2016*	Mitigation: • *Complete consultation over on-call rota*

management leads to reduced length of stay of patients on CS/MFFD list.	*Outcome Impact: June 2016*	• *Workforce communications and engagement strategy* • *Council engage with care homes over week-end admissions as new contracts are awarded by May 2016*

Action 9: Improve Flow Management in Swift Ward

Owner: Lloyd Brodrick (Walsall Council Group Manager, Integrated Health & Adult Social Care), Steven Vaughan, (WHT Interim Chief Operating Officer)

Problem to be solved:	Actions:	Progress:
Swift Ward is occupied by complex patients, some of whom with dementia, at risk of longest lengths of stay. Reduces available bed capacity.	• *Maintain additional discharge team* • *Maintain additional social care reablement hours* • *Maintain additional domiciliary care support hours* • *Reduce out of borough placements on the ward* • *Ensure Mental Capacity Act and appropriate, timely, dementia assessment undertaken*	• *Additional discharge team as at November has been maintained and reduced LoS has been sustained since November pilot.* Review: • *Can we bring the extra market capacity funded by Action 10 forward to April 2016?*
Intervention:	Impact:	Risks:
Continue the intensive supported discharge model started in November 2015	Additional 10 beds of post-acute capacity per day.	• *Delay completing DtA reprocurement exercise (Action 10) in timescale* • *Inability to recruit of specialist/experienced practitioners in Social Care Support Team* • *Availability of additional domiciliary care hours from the market* • *Inability to recruit additional reablement workers*
Rationale:	Due Dates:	Mitigation:
SWIFT project has demonstrated more successful outcomes based on a model of DtA at home with additional capacity for social care reablement and domiciliary care support	*Implementation: April 2016* *Outcome: August 2016*	• *Council to assign specific procurement capacity to complete Action 10 in timescale* • *Assign experienced practitioners from elsewhere* • *Apply specific contract for these extra hours*

		• *Recruitment campaign*

Action 10: Revise Discharge to Assess Pathway

Owner: Kerrie Allward (Walsall Council Associate Director of Commissioning), Sharon Wright (Walsall Council Head of Procurement)

Problem to be solved:	Actions:	Progress:
Insufficient options for patients medically fit for discharge but with further assessment needs other than bed-based. This impacts significantly on people with dementia	• *Decommission all current 40 beds in nursing homes and recommission 20 with enhanced specification* • *Include 3 beds in one nursing home for complex cases (i.e. mental health)* • *Appoint additional capacity to Social Care Support Team and extend remit of team to all discharge pathways* • *Arrange GP medical cover for 20 DtA beds* • *Increase social care reablement capacity by 300 hours* • *Commission additional 400 hours of domiciliary care from market* • *Ensure bed bureau check correct criteria and discharge planning arrangements are in place prior to placement with DtA* • *Agree a single shared pathway for access to DtA beds, including use of trusted assessor.*	• *Council to lead reprocurement/ recommissioning – not commenced yet* Review: • *Can we bring the extra market capacity forward to April 2016 to support the continuation of the SWIFT discharge pathway?*
Intervention:	Impact:	Risks:
Halve the number of DTA beds in nursing homes (from 40 to 20) and transfer funding to additional social care reablement capacity to support discharge to assess at home model	*CS/MFFD list average reduces to 50 with average length of stay reduced to 12 days. Average LoS in 20 DtA beds reduced by 25% compared to 40 bed model. Number of cases going through alternative DtA at home pathway increased by a factor of 1.5 compared to 40 bed model*	• *Complete reprocurement exercise in timescale* • *Recruitment of specialist/experienced practitioners in Social Care Support Team* • *Availability of additional domiciliary care hours from the market* • *Recruitment of additional reablement workers*

Rationale: *Experience of bed based model to date shows tendency for some families to expect that this becomes a long term placement instead of return home. SWIFT project has demonstrated more successful outcomes based on DtA at home*	Due Dates: *Implementation: June 2016* *Outcome Impact: October 2016*	Mitigation: • *Council to assign specific procurement capacity* • *Assign experienced practitioners from elsewhere* • *Apply specific contract for these extra hours* • *Recruitment campaign*

Governance Arrangements

The following groups have a key role in monitoring, delivering and holding to account improvements in the urgent care system:

i. System Resilience Group (SRG)

SRG is the forum where partners across the health and social care system in Walsall plan, oversee and hold eachother mutually to account for the delivery of a high performing urgent and emergency care system. This is the lead group accountable for delivery of the SRG Recovery Plan with core membership at CO / Executive Director level.

ii. SRG Operational Group

SRG Operational Group is the forum responsible for following up actions agreed at SRG, identifying new risks and opportunities affecting the recovery plan, assigning responsibility for delivery of key interventions and tracking progress. Items are escalated as necessary to SRG.

iii. Urgent Care Programme Board

A commissioning forum responsible for setting urgent care strategy, developing specifications and setting priorities for the longer term improvement of the urgent care system through commissioning, redesign and procurement.

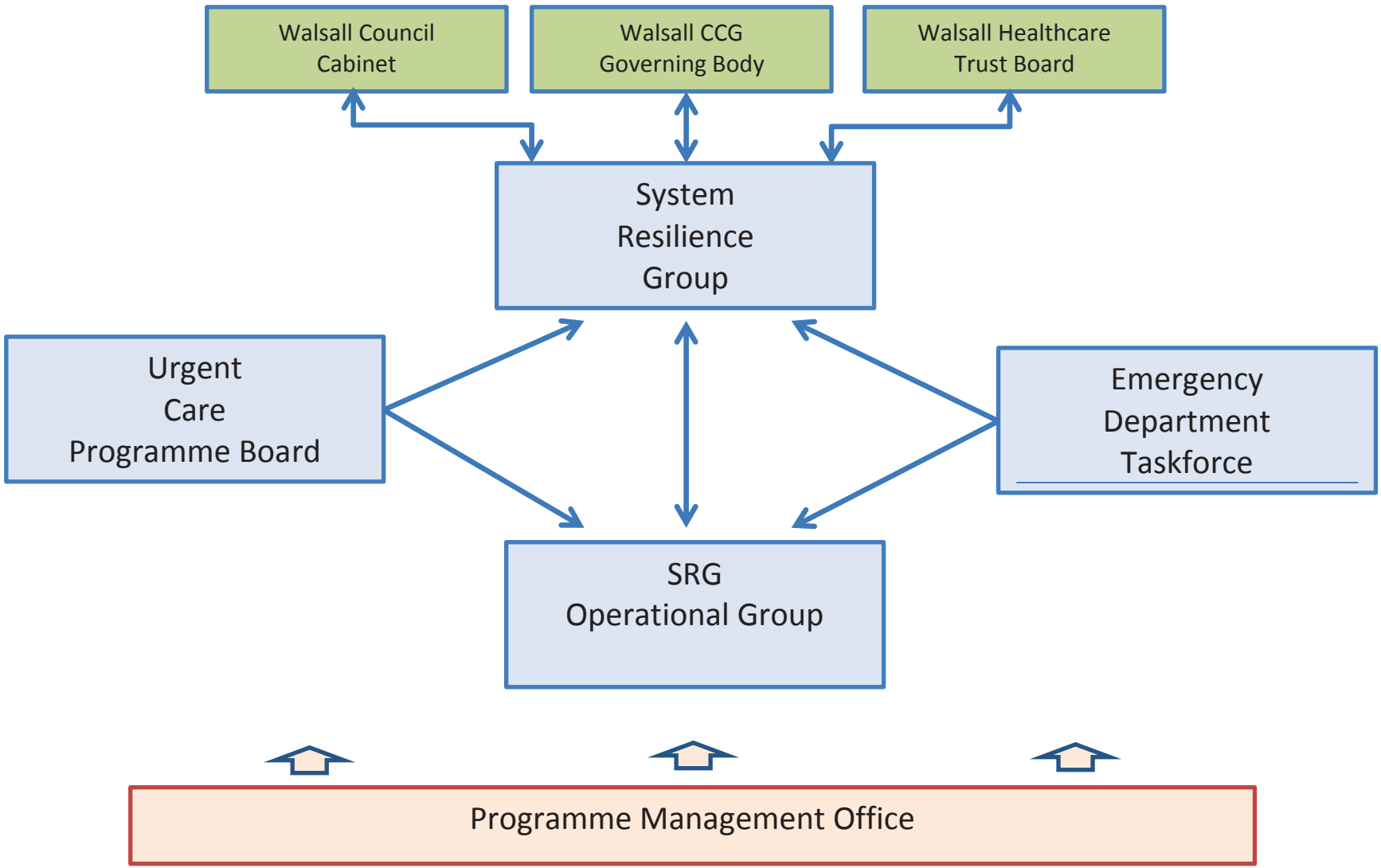
iv. ED and Emergency Care Taskforce

A Walsall Healthcare NHS Trust group which addresses the improvement of hospital services, processes and pathways affecting the Emergency Department. It's remit will address related improvement plans eg CQC, ECIP recommendations.

v. Programme Management Office

The Walsall system will apply a programme management approach to co-ordinate reporting of progress against the Recovery Plan, escalate risks and develop tools and techniques for monitoring and measuring performance improvement.

Governance Relationships for Urgent Care

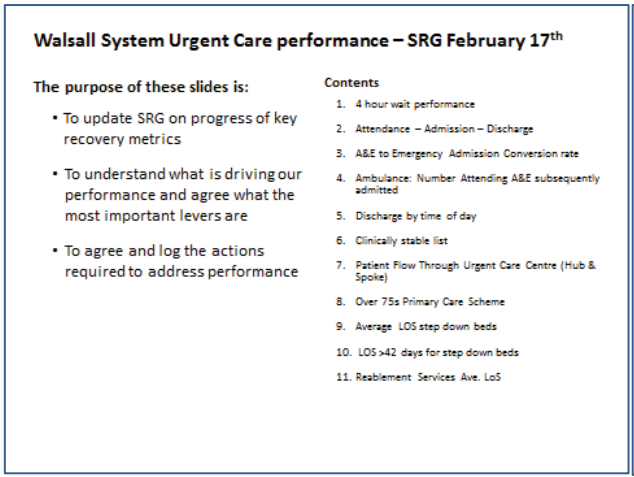


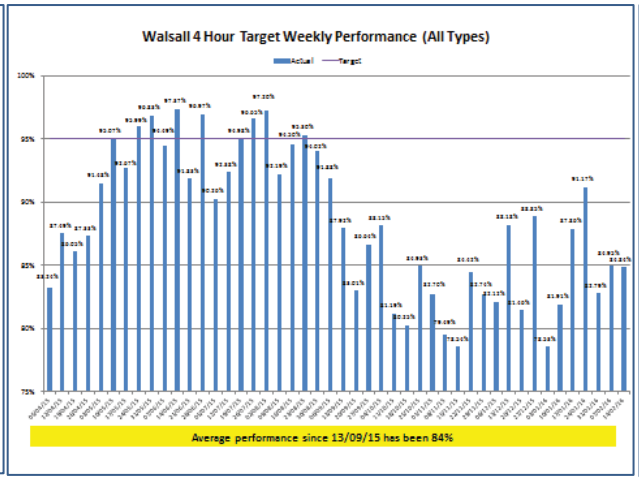
Performance Monitoring

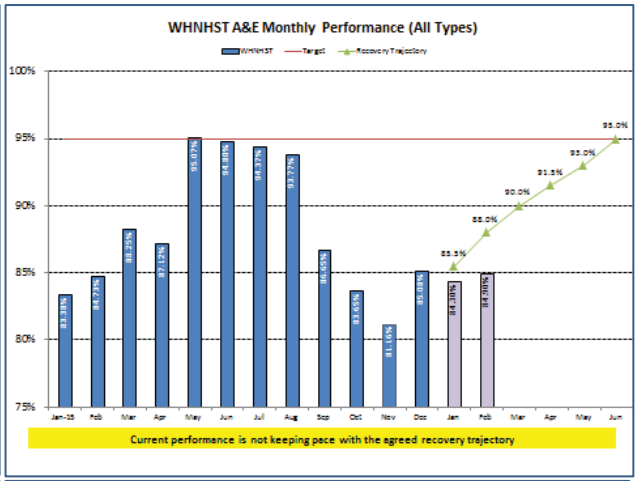
The SRG uses the following tools for assessing performance of the urgent and emergency care system:

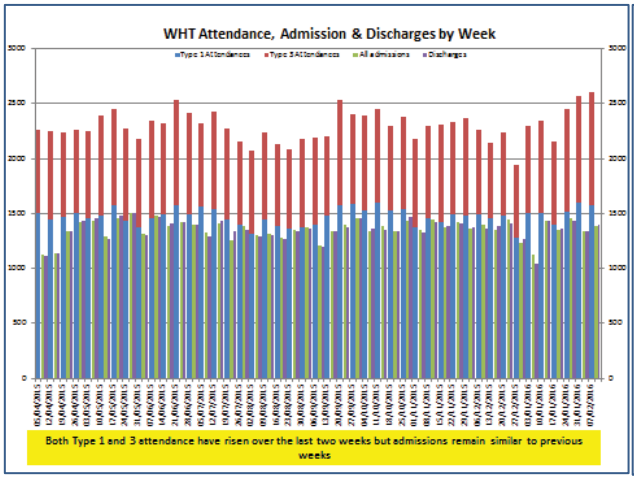
i. Performance Dashboard

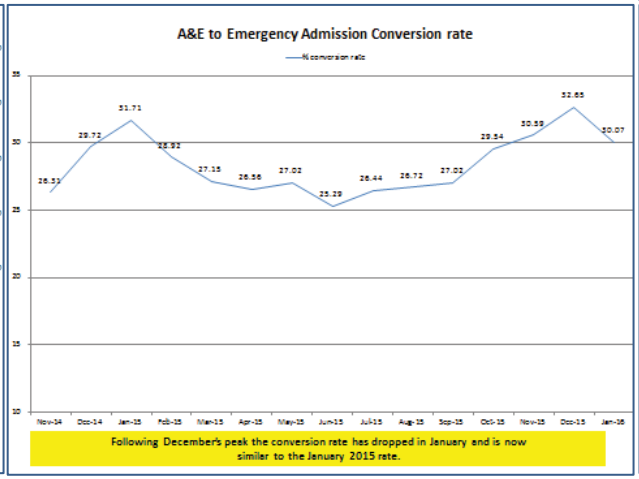
The SRG tracks performance across a range of indicators on a monthly basis, to identify trends and drivers of performance. E.g.

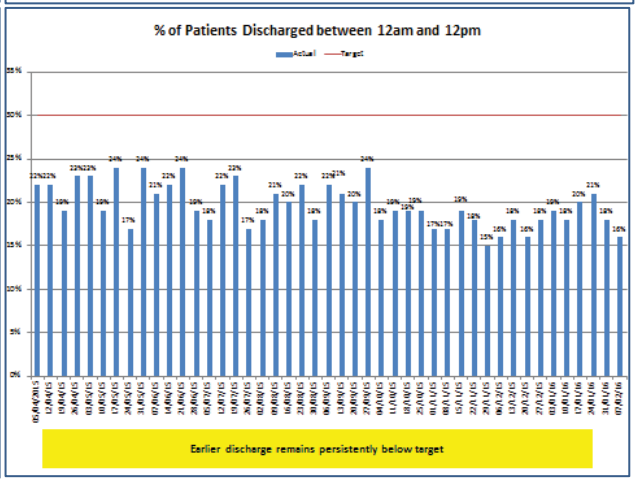






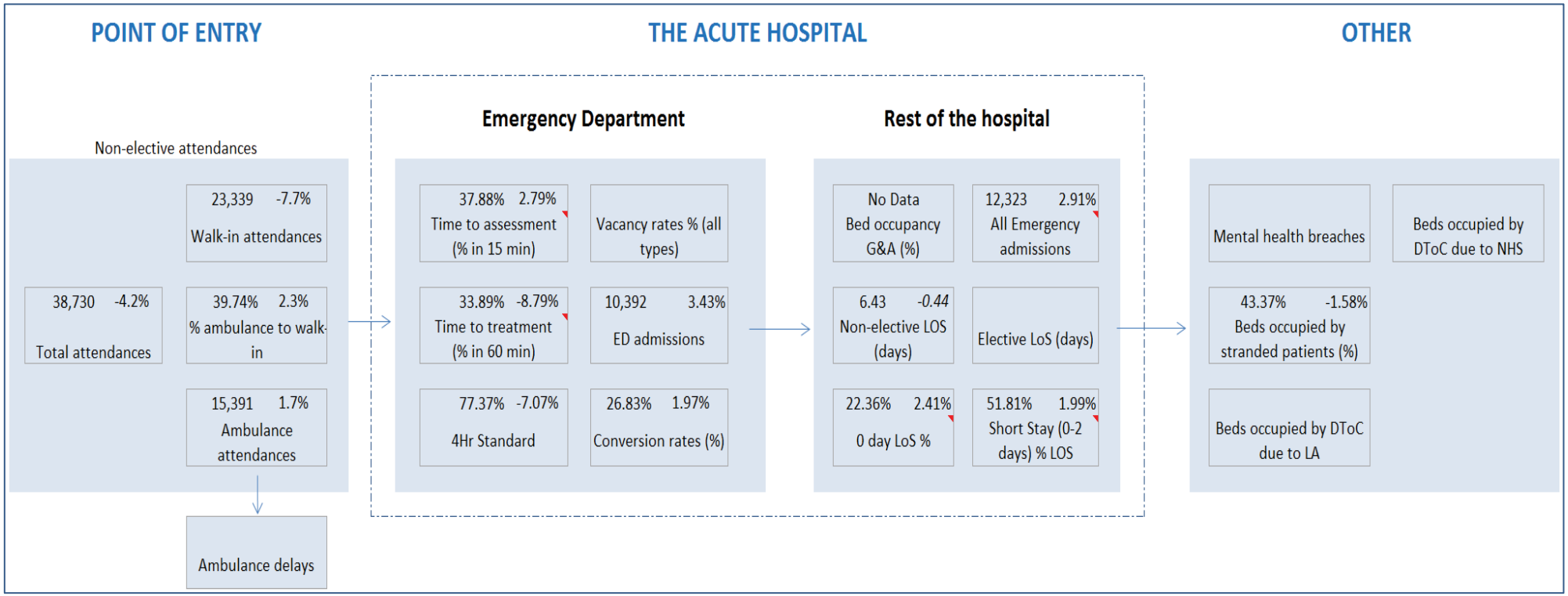






ii. ECIP Dashboard

The ECIP dashboard has been prepared by ECIP's informatics team to highlight a number of high impact metrics for SRGs review on a regular basis. We shall amend our local dashboard to incorporate the best practice available in informatics and reporting.



iii. Recovery Action Plans

Each key intervention will be supported by an action plan, which will bring together the key tasks, responsible owners, milestones, timescales, risks / mitigations and metrics to support their implementation. This will enable transparency and visibility of delivery for SRG, the constituents' Boards / Governing Body and regulators.

5. Recovery Trajectory

[This section to be enhanced with further support from ECIP / NHS England]

The measurable impact of each of our key interventions has been quantified. The next phase will be to translate this impact in to an assessment of 'breaches avoided' as a consequence of successful mobilisation of each action. In turn, breaches avoided can be expressed as a percentage improvement in our trajectory.

Given the long-standing nature of some of the challenges facing the Walsall urgent and emergency care system and the lead time required for some of our interventions, our first goal will be:

"To return A&E 4-hour performance to better than the England average by June 2016 – a target performance of 92%"

This will be delivered by our seven high impact interventions detailed above.

We are not content to remain at this level. The remaining three interventions are important to consolidate and sustain performance, improve our resilience as we approach winter 2016/17 and continue an upward trajectory towards 95% by Q4 of 2016/17.

Walsall Council

Equality Impact Assessment (EqIA) for Policies, Procedures and Services

Proposal name	Discharge to Assess Beds Pathway Re-tender		
Directorate	Adult Social Care		
Service	Adult Social Care		
Responsible Officer	Kerrie Allward		
EqIA Author	Kerrie Allward		
Date proposal started	1.5.16	Proposal commencement date (due or actual)	1.11.16

1	**What is the purpose of the proposal?**	**Yes / No**	**New / revision**
	Policy	**No**	**No**
	Procedure	**No**	**No**
	Internal service	**No**	**No**
	External Service	**Yes**	**Revision**
	Other - give details		

2 What are the intended outcomes, reasons for change? (The business case)

What is the intended outcome?

In October 2014, Cabinet was advised on the 'Joint Capacity Plan for Winter 2014/15' which was developed between Walsall Commissioning Clinical Group, Walsall Healthcare Trust and the Council was looking at ways of reducing Accident and Emergency attendance of people, particularly people aged over 75 years old. This plan aimed to reduce attendances to Accident and Emergency, reduce hospital admittance and reduce the length of stay and delays for those patients occupying a hospital bed who no longer needed medical treatment. This Plan stated it would be reviewed and may lead to further changes in time for 2015/16.

The Joint Capacity Plan for Winter 2014/15 has been replaced by the System Recovery Plan in December 2015 which is being monitored on a weekly basis with key stakeholders to improve the performance of the reducing hospital admissions.

The procurement process in 2014, resulted in 35 'step-down' and 5 'step-up beds' being block purchased from the successful contractors in 5 nursing homes and now funded within the 2015/16 Better Care Fund allocation.

The Health& Social Care System Recovery Plan has suggested the consolidation and reconfiguration of bed based 'step-down' and 'step-up' provision and the releasing of funding to support alternative provision to help older people return direct to their homes will yield improved outcomes and enhanced performance of service delivery.

Reason for change?
To improve:

- Outcomes for service users
- Accident and Emergency Performance at Walsall Manor Hospital
- Hospital discharges to prevent delays occurring

Who is intended to benefit?
The Council, Hospital, service users and their carers/family. The Council has a statutory duty to promote the health and wellbeing of its population. Inappropriately prolonged stays in hospital can have a detrimental effect on an individual's health and well-being. It is also evidenced that assessments to determine the long term health and social needs of an individual conducted in a hospital setting tend to be more risk averse and lead to inappropriately higher levels of provision, which can create dependency and further impact on an individual's health and well-being. A model of 'Discharge to Assess' that facilitates a timely discharge shall reduce the tendency for an older patient to 'decondition' (i.e. be at risk of permanent admission to a care home) and will allow more appropriate assessment of need for social care involvement.

The alternative model of 'Discharge to Assess' could reconfigure the existing funding to expand the range of alternative discharge pathways in line with the 'Recovery Plan':

- Decommission the 40 care home beds in nursing homes and recommission 20 care home beds with an enhanced specification. The capacity in the 'bedded' pathway could also be maintained by reducing the target length of stay in the 'Discharge to Assess' beds;
- Include 3 beds for complex cases (i.e. mental health);
- Appoint additional capacity to the 'Social Care Support Team', extend the remit of the team to support all discharge pathways and improve identification of appropriate patients for 'Discharge to Assess' at home;
- Arrange General Practitioner medical cover for the 20 'Discharge to Assess' beds to address and reduce high readmission rates (average 30%) – this would be commissioned and funded directly by Walsall Commissioning Clinical Group;
- Increase social care reablement capacity by 300 hours to enable return home; and
- Commission an additional 400 hours of domiciliary care/homecare from the market to enable people to stay at home after discharge.

It is envisaged that the multi-disciplinary team for example, social workers, a representative from the home, community matron, supporting the existing 40 'Discharge to Assess' beds will remain but increase their capacity to improve the performance of the service in terms of shorter length of stay, therefore, minimising the impact of bed reduction. The team will also work with hospital staff to support across each of the discharge pathways (both bed and community outcomes).

3 Who is the proposal potential likely to affect?

People in Walsall	Yes / No	Detail
All	**No**	
Specific group/s	**Yes**	**Older People, their carer's and family**
Council employees	**No**	
Other	**Yes**	**The existing Provider's staff - Aldridge, Arboretum, Ash Grange, Redhouse and Parklands Nursing homes.**

4	**Summarise your evidence, engagement and consultation.**

Evidence

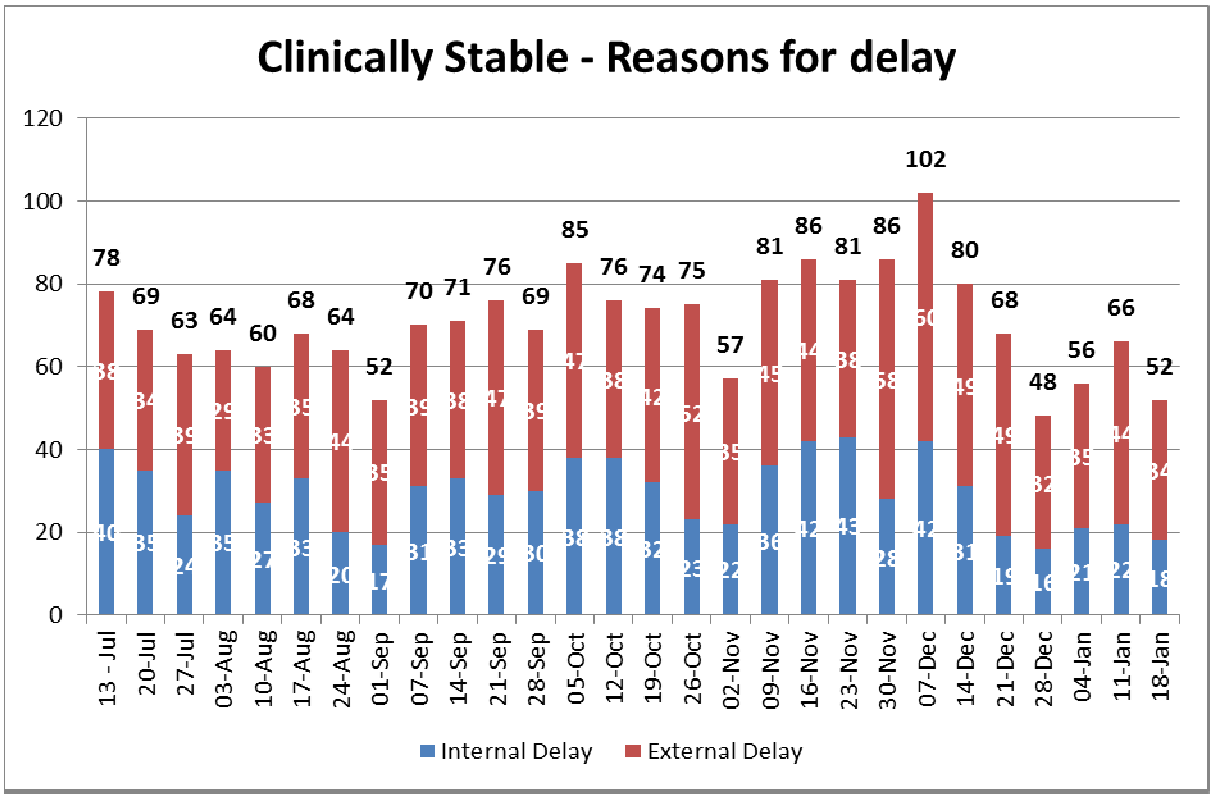
There is a link between discharges and Accident and Emergency performance with a national target that no less than 95% people who attend Accident and Emergency should be seen, admitted, treated or discharged within 4 hours of arrival. The monitoring of the Plan has suggested by the end of December 2015 the standard had only been achieved once in over 18 months at The Manor Hospital.

Two important initiatives forming part of the 'Recovery Plan' have been underway since December 2015:

- A reconfigured 'Frail Elderly Service' is helping to divert hospital admissions from within the Accident and Emergency Department; and
- The 'Swift ward project' is serving to reduce delay and accelerate discharge for those who are medically fit for discharge.

The enhanced multi-disciplinary approaches to supporting older people to go home are showing significant improvements in reduced care home admission rates and patient discharges out of hospital and are critical to meeting Accident and Emergency targets.

Reductions in the numbers of patients medically fit for discharge have been dramatic and consistent since the monitoring commenced as set out in the graph below.



Although the existing model of 'Discharge to Assess' has also supported this improvement, there have been some challenges, for example, in terms of high numbers of readmissions to hospital, longer lengths of stay in 'Discharge to Assess' beds (beyond the expected maximum of 6 weeks) and proposed outcomes not being delivered; for instance, too many people admitted to long term nursing care – especially those with dementia.

It has also been identified, from the Recovery Plan that a solely bed based model in care homes does not address the full range of needs of those being discharged from an acute

hospital setting and therefore a future report to Cabinet will seek approval, following key stakeholders consultation of an alternative model that is more focussed on discharge home to assess which requires longer term funding and new contracts to be put in place.

Consultation

To date consultation has been based on exit interviews of individual patients who are discharged from the discharge to assess beds and the feedback has been mixed. Some families have reported how they have found the arrangements excellent and others have reported that they were readmitted to hospital and so should not have been discharged, with a range of experience in between these which, along with feedback from further consultation for which this report seeks approval, will be taken into consideration in the remodelling of the service provision.

Further consultation will be undertaken as part of the procurement process to shape the new service.

5 **How may the proposal affect each protected characteristic or group? The affect may be positive, negative or neutral.**

Characteristic	Affect	Reason	Action needed Y or N
Age	Neutral	No significant impact foreseen.	N
Disability	Neutral	No significant impact foreseen.	N
Gender reassignment	Neutral	No significant impact foreseen.	N
Marriage and civil partnership	Neutral	No significant impact foreseen.	N
Pregnancy and maternity	Neutral	No significant impact foreseen.	N
Race	Neutral	No significant impact foreseen.	N
Religion or belief	Neutral	No significant impact foreseen.	N
Sex	Neutral	No significant impact foreseen.	N
Sexual orientation	Neutral	No significant impact foreseen.	N
Other (give detail)	Adult Social Care and Hospital work force would need to be briefed to understand the impact of this change and how to access support following the changes to the 'Discharge to Assess' pathway.		y
Further information	This remodel will not result in any reduction in funding; it will merely result in a reinvestment to fund a more effective model with improved outcomes for the Council, hospital and service user/carers.		

6	**Does your proposal link with other proposals to have a cumulative affect on particular equality groups? If yes, give details below.**	(Delete one) **No**

	No	
7	**Which justifiable action does the evidence, engagement and consultation suggest you take?** (Bold which one applies)	
	A	No major change required
	B	**Adjustments needed to remove barriers or to better promote equality**
	C	Continue despite possible adverse impact
	D	Stop and rethink your proposal

Now complete the action and monitoring plan on the next page

Action and monitoring plan				
Action Date	**Action**	**Responsibility**	**Outcome Date**	**Outcome**
April 2016	Under take consultation with former, existing, potential service users/ carers/health &social care professionals and current/potential providers	Older Person's Commissioning	May 2016	Gather information to inform the service specification and tender process.
November 2016 - ongoing	Continue weekly contract monitoring meetings to maintain effective working relationships with new providers to ensure new arrangements ensure are working.	Integrated Intermediate Care Team	On-going	Improved health and wellbeing, including independence of older people and the protection of vulnerable adults.

Update to EqIA	
Date	**Detail**
	.