North Yorkshire County Council

Equality Impact Assessment Template

Home from Hospital - v8 @11.7.12

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যদি আপনি এই ডকুমেন্ট অন্য ভাষায় বা ফরমেটে চান, তাহলে দয়া করে আমাদেরকে বলুন।

如欲索取以另一語文印製或另一格式製作的資料，請與我們聯絡。

اگرآپ کومعلومات کسی دیگرزبان یادیگرشکل میں درکارہوں توبرائے مہربانی ہم سے پوچھئے۔

Undertaking an Equality Impact Assessment

Equality Impact Assessments (EIA) should be undertaken at the business case stage when:-

- You are developing a new service or policy
- You are reviewing an existing service or policy
- You are proposing a change to an existing service or policy
- You are reviewing a service or policy carried out on behalf of the council or another organisation
- Your service is re-organised.

They should be referenced in your final recommendations on the service changes so that decision makers can reach an informed decision on the service/policy.

An EIA should cover all the social identity characteristics protected by equality legislation – referred to as **'protected characteristics'** or equality strands. These are;

- Sex
- Sexual orientation
- Religion or belief
- Race – this include ethnic or national origins, colour and nationality
- Disability – including carers
- Pregnancy and maternity
- Gender reassignment
- Age
- Marital/civil partnership status

There is a lot of information available to support you in completing this assessment on the EIA pages on the NYCC intranet

Equality Impact Assessments are public documents. Full EIAs accompanying reports going to County Councillors for decisions are published with the committee papers on our website and available in hard copy for people attending the relevant meeting. To make it easier for people to find equality impact assessments the Council will also publish full equality impact assessments on the NYCC website.

Name of the Directorate and Service Area	Health and Adult Services			
Name of the service/policy being assessed	Commissioning proposals for Home from Hospital Service			
Is this the area being impact assessed a	**Policy & its implementation?**		**Service?**	x
	Function		**Initiative?**	
	Project?		**Procedure & its implementation?**	
Is this an Equality Impact Assessment for a (Note: the Equality Impact Assessment (EIA) is concerned with the policy itself, the procedures or guidelines which control its implementation and the impact on the users)	**Existing service or a policy and its implementation?**			
	Proposed service or a policy and its implementation?			
	Change to an existing service or a policy and its implementation?			x
	Service or Policy carried out by an organisation on behalf of NYCC?			x
How will you undertake the EIA? Eg team meetings, working party, project team, individual Officer	An individual Officer to undertake the work which is then circulated to the Home from Hospital joint commissioning working group: membership HAS Officers, NYYPCT and locality Commissioning Officers.			
Names and roles of people carrying out the Impact Assessment	Stephen Harrison, Strategic Commissioning Manager Helen Thirkell, Procurement Officer Judith Knapton, Head of Commissioning (Adult and Community Services) NHS North Yorkshire and York Home from Hospital - Commissioning Working Group to act as Reference Group			
Lead Officer and contact details	Stephen Harrison 01609 533807			
Date EIA started	11th June 2012			
Date EIA Completed	11 th July 2012			
Sign off by Service Head/ Business Unit Head	N/A			

Sign off by Assistant Director (or equivalent)	Mike Webster [redacted]
Date of Publication of EIA	
Monitoring and review process for EIA	Integrated Partnership Board

1. Operating Context

Please consider issues around impacts (positive or negative) raised for **all** **protected characteristics** and show your evidence

1.1 Describe the service/policy What does the service/policy do and how? How would you describe the policy to someone who knows very little about Council Services? If there is a proposal to change the service or policy, describe what it looks like now and what it is intended to look like in the future. What are the drivers for this proposed change?	The Home from Hospital Service is to provide an individually tailored service of proactive, practical support for those vulnerable people that leave hospital and to help them settle back in to their own home having been in Hospital. It is expected that this service will support those people that have carers and family support. Health and Adult Services facilitates direct carer involvement in service development and information through the North Yorkshire Carers Forum which is open to anyone in North Yorkshire who is an unpaid carer for an adult who is ill, frail, disabled or has mental health or substance misuse problems. Effective intervention for carers highlighted by North Yorkshire's four voluntary sector Carers Resources include: Recognising and Involving Carers as expert care partners in health and hospital discharge planning. Within self-determined boundaries carers should be key players in all elements of health and social care assessment, planning and support delivery for those they look after. They should have access to training, equipment and information to support them in their caring roles just as paid care workers do.
Who does it benefit? What are its intended outcomes? Who is affected by the policy? Who is intended to benefit from it and how? Who are the	The Local Authority and Health Service don't currently have a County wide consistent approach for the delivery of a Home from Hospital Service. This would be an enhancement of service provision. North Yorkshire's Integrated Health and Social Care

stakeholders? identify those protected characteristics for which this service is likely to have an impact (positive or negative) Are there any other policies or services which might be linked to this one? Have you reviewed the EIA for these policies/services? What do they tell you about the potential impact? How will the policy be put into practice? Who is responsible for it?	Programme Board have agreed that this service should be commissioned as this service has been viewed as one of the essential building blocks to ensure the health and social care economy runs smoothly. The driver for this service development is to provide an equitable approach and service offer to benefit those people being discharged from Hospital. Through running an equitable County wide approach, the commissioners of the Home from Hospital Service, over time, will be in a better position to evaluate the equality of provision and delivery. This will help to ensure that all people can be confident and competent, to live independently. The services would be provided in partnership with the locality Neighbourhood / Community (Health and Social Care teams) which includes the Short Term Assessment & Reablement Team (START), Intermediate Care. This is to allow statutory services to focus on reablement and treatment. The service will have the flexibility to respond to local service developments. This service would be open to vulnerable adults. It is expected that it will benefit all groups as defined by protected characteristic but will have the greatest impact supporting disabled people and older people, and unpaid carers. In partnership the Health and Social Care (Neighbourhood / Community) teams, would assess the person's needs and requirements for the time of discharge and up to six weeks thereafter, and identify a short programme of practical support to facilitate the return of someone to their home after being in hospital. The aim of the support is to ensure the person's home environment is safe and warm and they have sufficient food, skills and ability to look after themselves. The Expected Outcomes for this new service would be • A reduction in re-admissions to hospital • A safer hospital discharge • An increase in the number of people being discharged back to their usual place of residence. • A reduction in people reporting feelings of isolation • An increase in the confidence of people and their carers to live independently and have an active life that meets their needs • Prevention of crisis situations that may lead to admission to acute care or loss of

	independence • An increase in the number of individuals reporting they are treated with dignity and respect • Contribution to a whole system approach that is responsive to a person's individual needs. The key areas of service that will be linked to this will be particularly around the policy and practice of assessment. This commissioned service will be accessed through both Health and Social Care staff, working through closer Integrated Teams. The service specification will include requirements for coordination of potential equality issues, e.g. whether diverse communities are accessing the service, whether the service meets the needs of diverse communities, accessibility etc. This service is not available to vulnerable people that require specialist support for daily living and maintaining their health and independence such as those with more advanced dementia or mental health problems; those whose permanent residence is outside the PCT and NYCC boundaries; or whose GP is outside the area. For these inappropriate referrals the person should be signposted to the appropriate local support. The service will be jointly commissioned between NYCC Health and Adult Services and NHS NY&Y Cluster / CCG.
1.2 How do people use the policy/service? How is the policy/service delivered? How do people find out about the policy/service? Do they need specialist equipment or information in different formats? How do you meet customer needs through opening times/locations/facilities? Can customers contact your service in different ways? How do you demonstrate that your service/policy is welcoming to all groups within the community? Does the policy/service support customers to access other services? Do you charge for your services? Do these changes affect everyone equally? Do some customers incur greater costs or	The service is aimed at those vulnerable people who are admitted to hospital (General Acute Trusts or Community Hospital) who need support upon discharge to gain confidence and rehabilitate within a six week period, within the NYYCC boundaries and/ or GP practice population. People would find out about the service ***/*** delivery through the referral process from Health and Adult Services, health staff. This would come directly from the Neighbourhood / Community Teams including START, Intermediate Care / Hospital / GP / Care manager for planned and for unplanned admissions and the hospital staff, discharge team or social care worker may refer to the service once an admission has taken place. The service is also expected to support those people who have been discharged back to home in North Yorkshire from hospitals outside of North Yorkshire.

get 'less for their money'? Are there eligibility criteria for the service/policy? How do you ensure that staff/volunteers delivering the service follow the Council's equality policies? Does the Council deliver this policy in partnership or through contracts with other organisations? How do you monitor that external bodies comply with the Council's equality requirements?	All clients will receive an appropriate response within an agreed time-frame. Days/Hours of operation would be to support discharge element of the service from 7.30am to 9pm and where appropriate the overnight service between 9pm to 7.30am, seven days per week. A self support approach should be taken to provide vulnerable people with the knowledge and skills to live independently as far as possible. Access other ongoing community services and self sustain activities that benefits independent living and social networking will be required to also encourage customers to access other services All service users and their carers are expected to receive relevant information and signposting to other services as appropriate in a format that meets their needs. The Geographic coverage/boundaries for referrals into this service must be for people who reside within North Yorkshire County Council boundary. Location(s) for the Service Delivery is to ensure the service is accessible by vulnerable people who reside within NYCC boundary who will be discharged from general hospitals or Community Hospitals, EPHs (step down) Providers are contractually obliged through procurement and contract arrangements to meet the Local Authority and Health and Adult Services Directorate required standards and have policies and practices in place to meet the council's equality standards. Providers are expected to meet the Directorate's Quality Outcomes Framework. This has a number of standards against which providers are assessed: • Assessment and Support Planning: All clients receive an assessment of their support needs and any associated risks • Security, Health and Safety: The security, health and safety of all individual clients, staff and the wider community are protected. • Safeguarding and Protection from Abuse: There is a commitment to safeguarding the welfare of adults and children using or visiting the service and to working in partnership to protect vulnerable groups from abuse. • Fair Access, Diversity and Inclusion: There is a demonstrable commitment to fair access, fair exit, diversity and inclusion. The service acts within the law and ensures clients are well-informed about their rights and responsibilities. • Client Involvement and Empowerment: There is a commitment to empowering

	clients and supporting their independence. The service specification includes requirements around staff training and skills, including equality, diversity, dignity and safeguarding.

2. Understanding the Impact (using both qualitative and quantitative data)

Please consider issues around impacts (positive or negative) raised for **all protected characteristics** and show your evidence

2.1 What information do you use to make sure the service meets the needs of all customers? What data do we use now? Is it broken down across protected characteristics (and are these categories consistent across all data sets)? How current is the data? Where is it from? Is it relevant? What engagement work have you already done that can inform this impact assessment? Who did you talk to and how? What are the main findings? Can you analyse the results of this consultation across the protected characteristics? Are there differences in response between different groups? How has this changed the plans for the policy/service?	In October 2010 funding for re-ablement was linked to hospital discharge specifically in relation to the allocations to PCTs of an additional £70 million available for post-discharge support. The Department of Health described how nationally, all PCTs should develop local plans in conjunction with the Local Authority and FT/NHS Trusts and community health services on the best way of using this money to facilitate seamless care for patients on discharge from hospital and to prevent avoidable hospital readmissions. The NHS NORTH YORKSHIRE AND YORK BOARD MEETING - 22 May 2012 - Paper titled: 'Transforming Community Services – From Transfer to Transform' identified a number of Hospital Discharge issues and actions. These were to undertake a review of discharge process; Discharge Steering group to be established with an initial 4 work streams and priories agreed for the next 6 months; to develop good links with the Local Authority on taking forward work to improve discharge processes; to undertake a pilot of contacting patients post discharge to obtain feedback on their experience; and to undertake a review of discharge process. We know that social care services generally find it difficult to reach some groups, for example some minority ethnic groups including Gypsy, Roma, and Traveller communities. These communities are more likely to access health care services, so it may be that the new services are more able to reach diverse communities. A requirement for outreach / liaison with services that work directly with minority communities will be included in the service specification. Hospital discharge and planning is an issue that has been raised through discussions at the Carers Forum. Carers have said that they would like to be involved more in the

	planning of hospital discharge and following hospital discharge, that they require better information about what services, support that may be available to them locally.
2.2 What does the information tell you? Are there any differences in outcome for different groups e.g. differences in take up rates or satisfaction levels across groups? Does it identify the level of take-up of services by different groups of people? Does it identify how potential changes in demand for services will be tracked over time, and the process for service change? **Please include data and analysis as an appendix**	The demographic profile of North Yorkshire shows that the number of people living on their own is rising in line with the rising age profiles of the area; the tables also suggests that in these later years people's ability to manage simple tasks reduces without support. The County also has a significant numbers of Carers who would benefit from the Home from Hospital Service.

Indicator	**Year**		
	2011	**2020**	**2030**
Living alone, aged 75 and over			
North Yorkshire	29,293	37,817	51,496
Craven	3,236	4,003	5,428
Hambleton	4,247	5,984	8,101
Harrogate	7,652	9,912	13,325
Richmondshire	2,042	2,741	4,064
Ryedale	2,802	3,596	4,831
Scarborough	6,092	7,395	9,763
Selby	3,046	4,186	5,991
Unable to manage at least one domestic task on their own, aged 75 and over			
North Yorkshire	33,909	44,360	62,243
Craven	3,799	4,754	6,625
Hambleton	4,871	6,926	9,750
Harrogate	8,894	11,762	16,311
Richmondshire	2,358	3,209	4,918
Ryedale	3,246	4,227	5,843
Scarborough	7,085	8,619	11,738
Selby	3,467	4,831	7,112

Projecting Older People Population Information System. Available at www.poppi.org.uk.

Long term conditions

The North Yorkshire Review has identified that 18.6% of emergency admissions in the

	North Yorkshire & York cluster can be classified as a long term condition (LTC), significantly higher than the region and England averages. Of the 11,000 Long Term Conditions emergency admissions in the NYY cluster in 2010/11, 79.9% were first admissions. This is significantly higher than the percentage of first admissions for all emergency admissions, meaning there are significantly less repeat emergency admissions for LTC. Nearly 68% of all repeat admissions were first repeat admissions (18% second repeat admissions and 7% third repeat admissions). Based on the national figure that 12% of the over 16 year population are carers, in North Yorkshire there are an estimated 60,000 carers in North Yorkshire. People aged 65 and over providing unpaid care to a partner, family member or other person (2011 estimates) District Carers: Craven 1,450 Hambleton 2,176 Harrogate 3,550 Richmondshire 1,026 Ryedale 1,260 Scarborough 2,926 Selby 1,593 North Yorkshire 13,981 In the JSNA, it was reported that one of the Big Issues for Hambleton District was the need for effective hospital discharge planning. Anecdotal feedback from the community groups e.g. Physical and Sensory Impairment Partnership Board, North Yorkshire LINk, Older Peoples Partnership Board, indicates that hospital discharge is an area of particular concern.
2.3 Are there areas where we need more information? How could we get this information? What data is available? Do other directorates, partners or other organisations hold relevant information? Is there relevant information held corporately e.g. compliments and complaints? Are	Partner organisations and ourselves hold little accurate data that might inform an Equality Impact Assessment for this Home from Hospital service. More engagement and closer working through Neighbourhood Care Teams and Integrated Teams is taking place across the County. This Joint Reablement funded contract will be useful to help provide further evidence as to who is accessing services, and how they are accessing them. From this evidence it's expected that the benefits in service provision will

there national datasets that would be useful? Is there relevant census data? Do you need to collect more data? How could you do this? Do you need to do more engagement work to inform this impact assessment? Have you identified information in other sections of this EIA that you need to assess the impact on different groups of people? What do you want to find out? Which existing mechanisms can you use to get this information? Please refer to the Community Engagement toolkit on the NYCC intranet	be better understood, and any gaps identified.
2.4 How will you monitor progress on your policy/service, or take-up of your service? What monitoring techniques would be most effective? What performance indicators or targets would be used to monitor the effectiveness of the policy/service? How often does the policy/service need to be reviewed? Who would be responsible for this?	Evidence will be gathered following the implementation of a more consistent County wide approach, and used to assess how the following outcomes are being experienced by the different groups in relation to: • A reduction in re-admissions to hospital • An increase in the number of people being discharged back to their usual place of residence. • A reduction in people reporting feelings of isolation • An increase in the confidence of people to live independently and have an active life that meets their needs • Prevention of crisis situations that may lead to admission to acute care or loss of independence • An increase in the number of individuals reporting they are treated with dignity and respect The services will be monitored through the quarterly returns from service providers and new enquiries will be analysed by age, ethnicity, gender, faith, disability characteristics. The baseline of numbers and profile of service users from 2011/12 where available will be used as a benchmark to measure if the revised arrangements are having any impact of take up and outcomes. As part of the review of the revised arrangements, a sample of customers will be analysed to inform continuation arrangements.

3. Assessing the Impact

Please consider issues around impacts (positive or negative) raised for **all protected characteristics** and show your evidence.

3.1 Has an adverse impact been identified for one or more groups? Has this assessment shown anything in the policy, plan or service that results in (or has the potential for) disadvantage or discrimination towards people of different groups? Which groups? Do some needs/ priorities 'miss out' because they are a minority not the majority? Is there a better way to provide the service to all sections of the community?	No adverse impact identified. This is a positive service development and does not involve a reduction or removal of existing services. **Age and disability** There should be a positive impact for disabled and vulnerable and frail people, in particular older people. Information will need to be in accessible formats to ensure that disabled people can access it. Carers Positive impact as people with unpaid caring role will have more support to assist their cared for person's return home from hospital. **Sexual orientation / Transgender** There may be a positive impact as research shows that older Lesbian, Gay, Bisexual and Transgender people are less likely to have the same levels of family support as heterosexual people. **Gender** There is some differential impact on grounds of gender as a higher proportion of people accessing social care overall are women, and a higher proportion of family carers are women. This means that overall, any positive impact will affect more women than men. **Ethnicity** Potential for positive impact as some minority ethnic people are more likely to access GP and hospital care than social care, and therefore this proposal will provide an additional access point. However, there is some potential for inequity of access if information and advice is not accessible to people with different language requirements.

	Faith/sexual orientation/ pregnancy and maternity/marriage and civil partnership Neutral.
3.2 How could the policy be changed to remove the impact? Which options have been considered? What option has been chosen?	No adverse impact.
3.3 Can any adverse impact be justified? If the adverse impact will remain, can this be justified in relation to the wider aims of the policy or on the grounds of promoting equality of opportunity for one target group? **Please seek legal advice on whether this can be justified.**	No adverse impact.
3.4 Are you planning to consult people on the outcome of this impact assessment? When and how will you do this? How will you incorporate your findings into the policy?	We will be undertaking further engagement on provision of a Home from Hospital Service with the Older Peoples Partnership Board, Physical and Sensory Impairment Board and, if possible, the LINk.
3.5 How does the service/policy promote equality of opportunity and outcome? Does the new/revised policy/service improve access to services? Are resources focused on addressing differences in outcomes?	The proposed new Home from Hospital Service and the specification for this will promote equality of outcome by creating a consistent approach for Home to Hospital services county wide.
Don't forget to transfer any issues you have identified in this section to the Equality Action Plan	

Action Plan					
What are you trying to change (outcome)?	**Action**	**Officer responsible**	**Deadline**	**Other plans this action is referenced in (e.g. Service Performance Plan, work plan)**	**Performance monitoring**
To ensure that monitoring includes data on equality profiling order to be able to assess the quality of the uptake and outcomes with regards to accessibility etc.	Contract monitoring and the assessment and analysis of access and availability of the service across protected characteristics.	HAS - Assistant Director Contracting, Procurement and Quality Assurance	July / August 2013		Forms part of the annual contract management process and is reported locally and through to HAS Management Board and to various Partnership Commissioning Boards and organisations.
New Services will be expected to liaise with specialist providers or networks for hard to reach groups, for example (Gypsy, Roma, Traveller, Showpeople communities).	Contract monitoring and the assessment and analysis of access and availability of the service across protected characteristics.	HAS - Assistant Director Contracting, Procurement and Quality Assurance	July / August 2013		Forms part of the annual contract management process and is reported locally and through to HAS Management Board and to various Partnership Commissioning Boards and organisations.

The need to involve Carers and family members in the planning for Discharge and discussions with the appointed Service Provider.	Need to ensure that this is identified within the service specification which will form part of the tender work	Helen Thirkell - Contracting Procurement & Quality Assurance (HAS)	July 2013		