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DRAFT: Equality Delivery System (EDS): Intermediate Care Services Grading Report March 2025

Purpose of the report

The ICB is required to engage with the system providers to identify 3 services per annum to be subject to the equality delivery System (EDS) grading. This would be based on three services which fall into one of these categories:

- There is best equality practice and outcomes
- There is little or no improvement in equality practice and
- Where there is little known as no equality monitoring is identified

For 2024/5 Three services were identified for EDS grading:

- Chaplaincy Services
- **Intermediate Care (Discharge Pathway 1)**
- Perinatal Mental Health services

This report sets out the results of the Intermediate Care EDS grading exercise. It includes the grading result and suggested improvement actions for the service to consider. The results will contribute to the systems overall rating (and that of the ICB) combined with Domains two and three grading and will also help towards any CQC inspections as part of their 'Well Led Domain' assessment.

Engagement and Grading Exercise

The two proposed grading workshops were advertised through comms & engagement teams from the Local Authority and ICB. The stakeholders invited were representative of the protected groups, socio-economic demographic groups/communities and other people living locally. Unfortunately, only one person turned up at the first workshop on 25th February who agreed to attend the second session instead (which was readvertised).

Five people attended the second grading workshop on 27th February; however, participants wanted more time to reflect and score. Subsequently, the deadline was extended by two weeks and followed up with a reminder to respond a week later. We received feedback and scores from five people (one more that the Maternity Diabetes workshop held the year previously). Despite the low attendance the evidence collected has been invaluable

around the protected groups and received very positive feedback from peers. This will be used for future planning ahead.

What is Intermediate Home Care Service?

Intermediate care (Step down, also referred to as intermediate care beds or high-dependency beds, are one possible approach to providing higher levels of care while improving the efficiency of patient flow.) It involves community-based assessments and interventions provided to people in their own home:

- Home-based; Discharge Pathway One,
- Short-term community bedded settings; bed-based discharge pathway two.

Home-based intermediate care is the default pathway as per the 'home first' approach (a person's home is their usual place of residence). Someone may be discharged from bed-based to home-based intermediate care to continue their intermediate care. For most people in acute hospitals, a simple discharge home without the need for step-down intermediate care is the most appropriate pathway (discharge pathway 0).

Intermediate care services can be entirely health care, entirely social care, or ideally have elements of both delivered by multi-disciplinary teams working in integrated ways.

Intermediate care focuses on step-down– time-limited, short-term (typically no longer than 6 weeks) health and/or social care provided to adults (aged 18 years or over) who need support after discharge from acute inpatient settings and virtual wards to help them rehabilitate, re-able and recover.

Expected Outcomes

Implementation of step-down intermediate care is expected to result in improved outcomes, experiences and independence of people discharged, reduced avoidable hospital readmissions, and reduced avoidable/premature long term care provision. Further expected benefits include improved flow and discharge from acute and community hospitals, freeing-up NHS hospital capacity for those who need it most.

LLR – Data

- Pathway 1 data comprises of discharges from both UHL hospital & Community hospital beds to home (discharged home with a new or increased Package of Care (POC).
- Data analysed P1 hospital discharges to home with a new or increased package of care (data analysed from LLR discharge hub data pack).
- Pathway 1 Discharge Data diagnostic period was from 1st October 23 to 31st September 2024.
- Pathway 1 comprised of 3702 service users and 4406 instances.
- Average length of stay was 3 days for all service users between 1st October to 31st September 2024.

UHL-Data

- 3425 patients (58%) on pathway 1c from a total of 5866 instances.
- Data taken from Sept 2023 to Sept 2024
- Overall average LOS was 15.87 days

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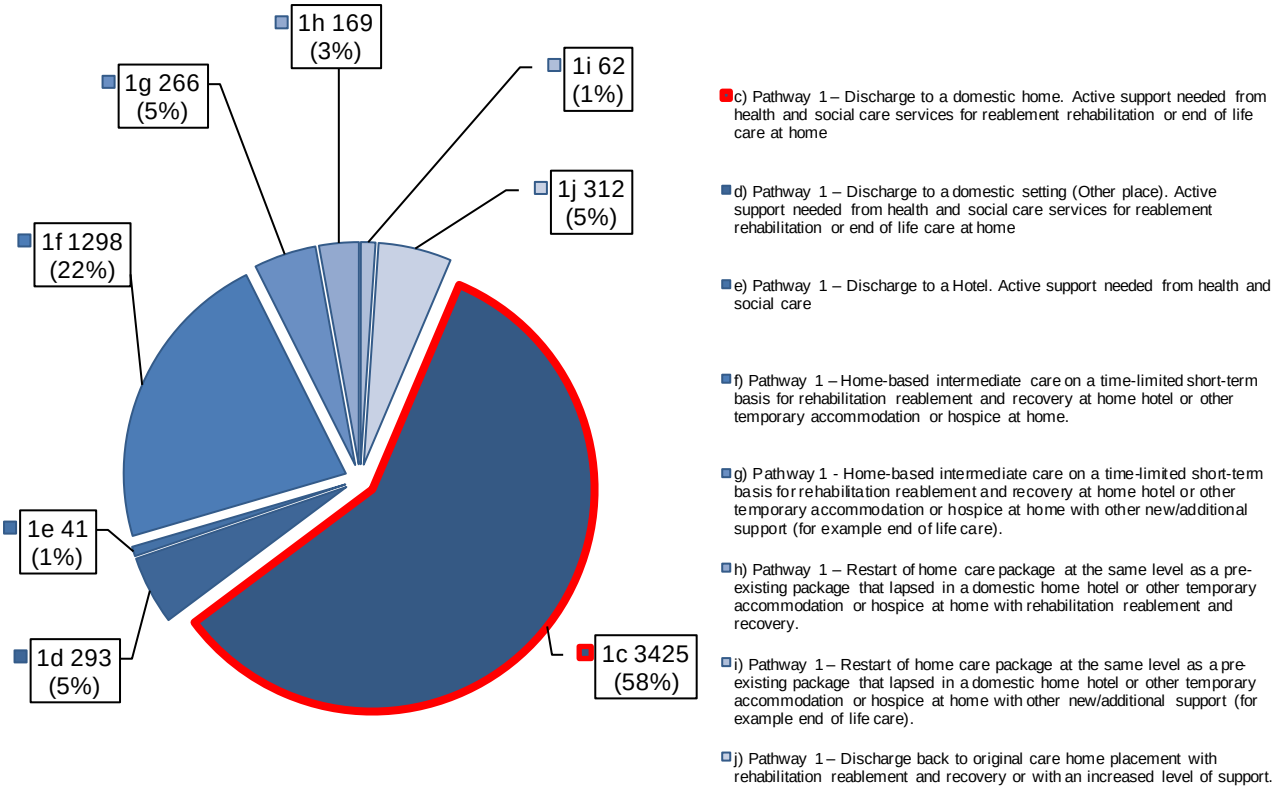


Outcome 1A Patients (service users) have required levels of access to the service

KEY *LOS = Length of stay

Data and evidence demonstrate that those with higher risk due to protected characteristics or at risk of inequalities have adequate access, patients report to receiving a good level of care and accessibility to the service. Accessibility to intermediate care is an equal rights service which hasn't demonstrated any form of discrimination for those patients from protected characteristics. The service is provided as and when required and to those that require it.

The following data provides a patient overview:

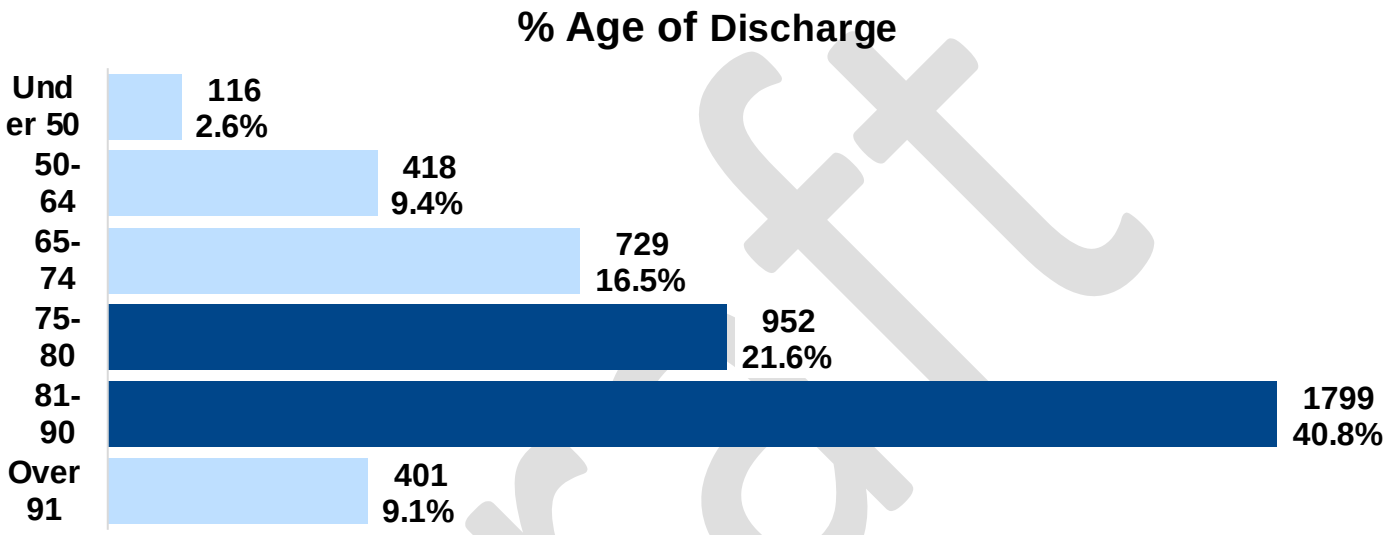
LLR

- Pathway 1 LLR data comprised 3742 patients with 4406 discharge instances (15% of patients were re-admissions across this data review period)
- 56% of discharged patients were female and 44% male
- 83.5% of patients discharged were from non-minority ethnic groups
- 16.5% of patients discharged were from a minority ethnic group.

UHL

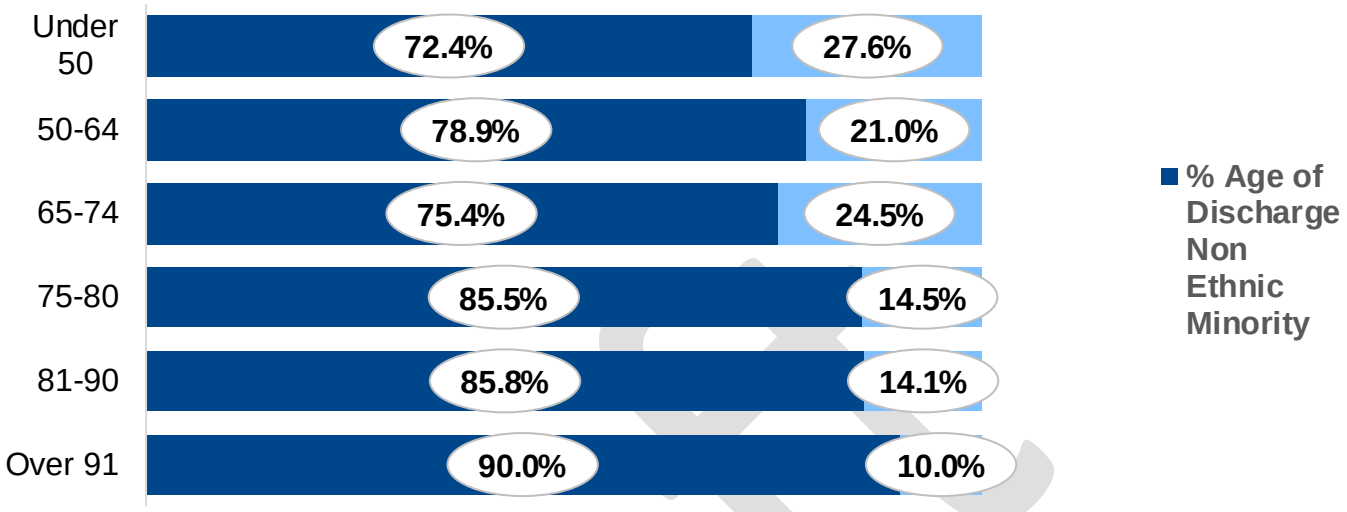
- Pathway 1c data compromised of 3425 patients
- Protected characteristics suggest a significant impact on Length of stay (LOS)
- Number of discharges for some characteristics unlike what was expected in relation to area population data

LLR Demographics



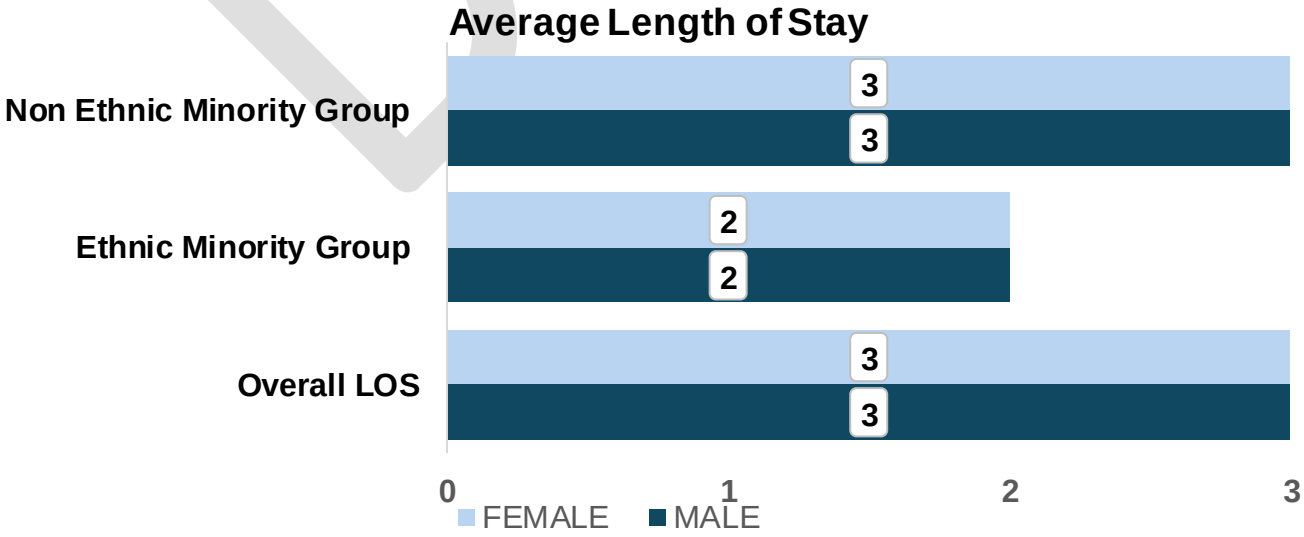
- Most of our service users are between 65-103 years of age (88%), this is very much aligned with frailty and the growing aging population.
- 12% of the service users were under 64.

% Discharge Age proportionate Minority Ethnic V Non-Minority Ethnic group



The above data demonstrates the demand between different age groups alongside ethnic and non-ethnic minorities that have accessed the intermediate care service across diagnostic period.

- Accessibility to service and the length of stay – averages across all patients was 3 days during the diagnostic period.
- Both the male and female population split from non-ethnic minority had an average of 3 days length of stay.
- Those from a minority ethnic groups' average length of stay of 2 days both for Male and Female.



KEY *LOS = Length of stay

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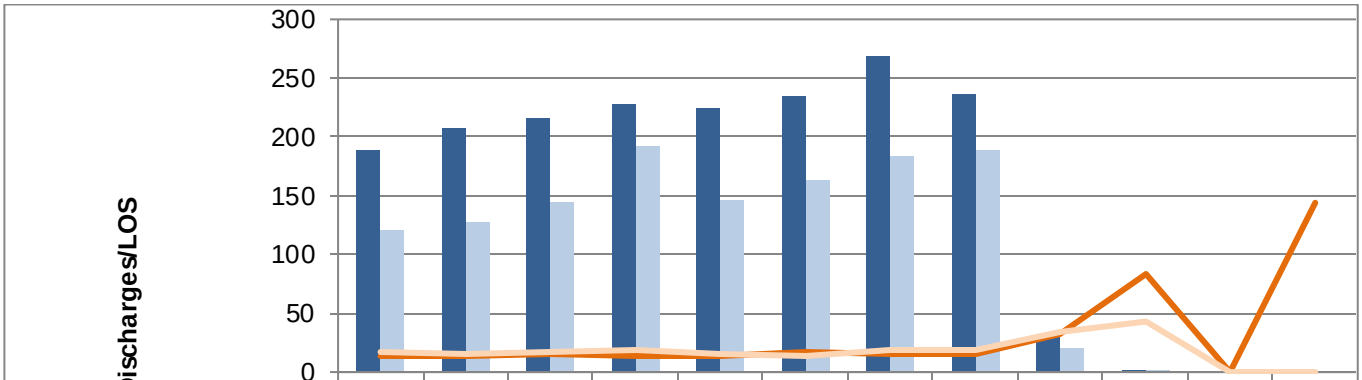
UHL Demographics

Monthly Average LOS and number of Discharges by sex



	31/10/2023	30/11/2023	31/12/2023	31/01/2024	29/02/2024	31/03/2024	30/04/2024	31/05/2024	30/06/2024	31/07/2024	31/08/2024	30/09/2024
Female Discharges	189	207	216	228	224	234	269	236	30	2	0	1
Male Discharges	121	128	144	192	147	163	183	189	20	2	0	0
Average LOS (F)	13.3	14.1	15.1	12.9	14.3	17.6	15.3	15.8	31.6	83	0	144
Average LOS (M)	16.4	15.2	17.1	18.1	16.2	14.2	18.1	18	34.4	43	0	0

- Total discharges: Female 1836 (58.8%) Male 1289 (41.2%)
- Average LOS: Female 31.4 (14.8 for months with 100+ discharges) Male 17.6 (16.6 for months with 100+ discharges)

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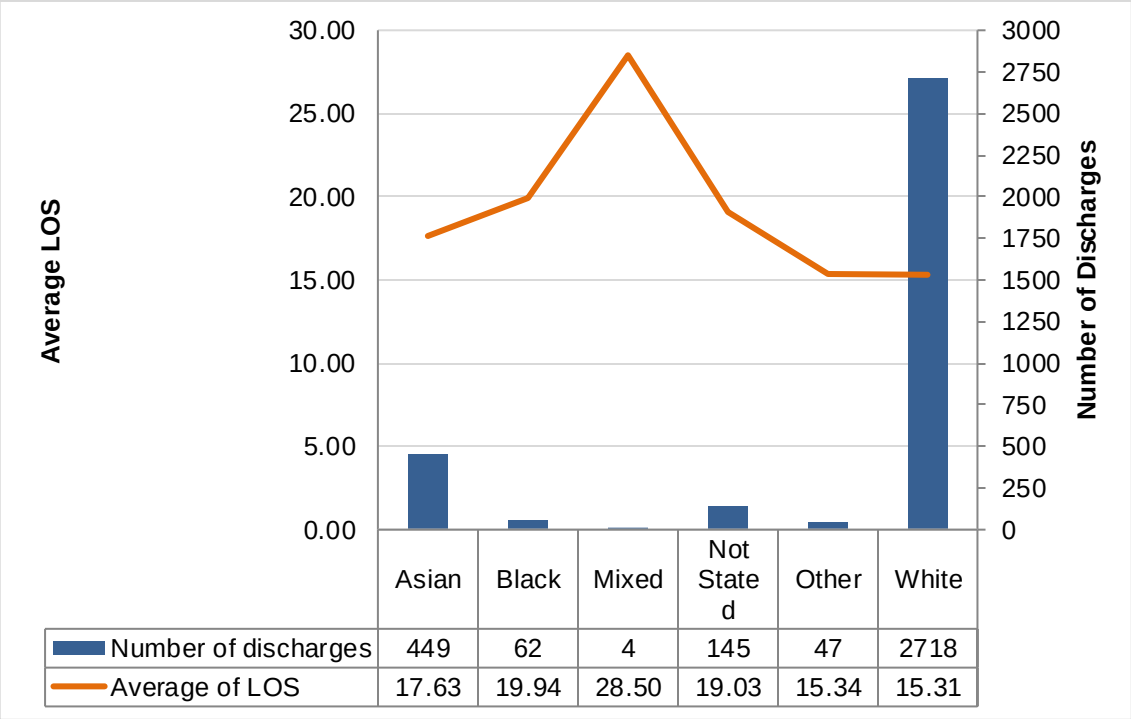
Average LOS and Number of Discharges by Ethnicity



	Asian	Black	Mixed	Not Stated	Other	White
Number of discharges	449	62	4	145	47	2718
Average of LOS	17.63	19.94	28.50	19.03	15.34	15.31

Please note:
'Asian' includes patients who identify as the following: Asian/Asian Brit Bangladeshi, Asian/Asian British Indian, Asian/Asian British Pakistani, Any Other Asian Background.
'Black' includes patients who identify as the following: Black/Black British African, Black/Black British Caribbean, Any Other Black Background
'Mixed' includes patients who identify as the following: Mixed White & Black Caribbean, Any Other Mixed Background
'White' includes patients who identify as the following: White British, White Irish, White Other White Background

- 79.3% of discharged patients identify as 'White' compared to 74.6% of population according to 2021 census
- 13.1% of discharged patients identify as 'Asian' compared to 17.6% of population according to 2021 census
- 1.8% of discharged patients identify as 'Black compared to 1.8% of population according to 2021 census
- 0.1% of discharged patients identify as 'Mixed' compared to 4.6% of population according to 2021 census

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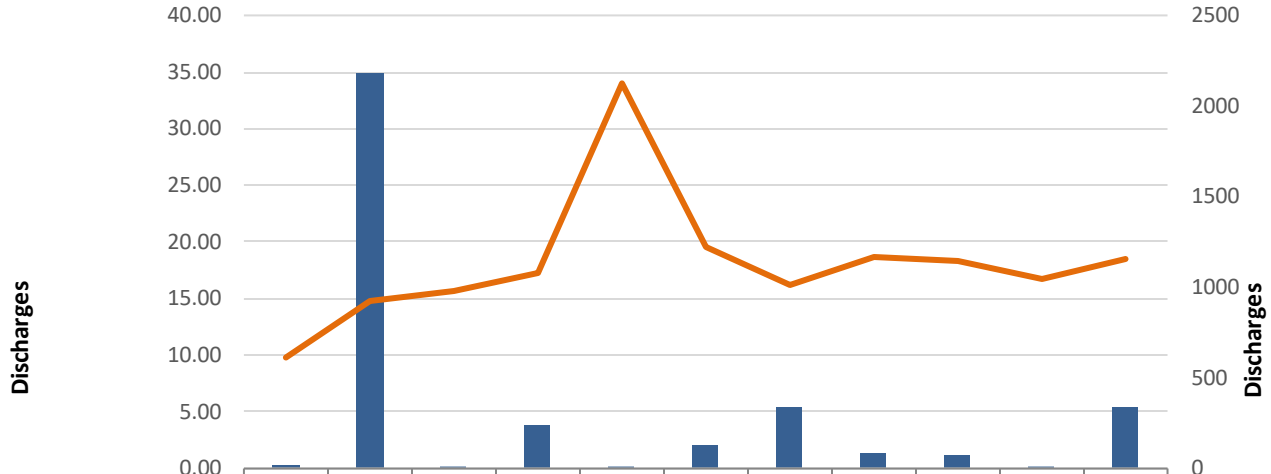
Average LOS and number of Discharges by Religion



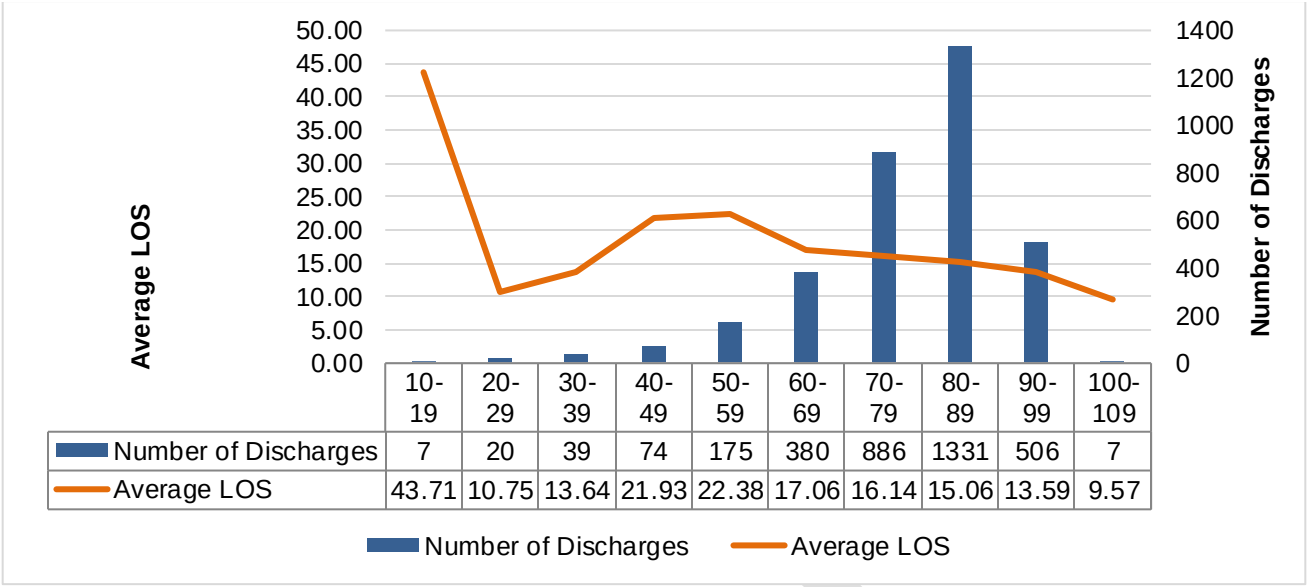
	Buddhism	Christianity	Eastern Orthodox	Hinduism	Judaism	Muslim	Non-Theistic	Other	Sikhism	Spiritualism	Unknown
Number of discharges	15	2180	3	244	1	135	340	82	71	10	344
Average of LOS	9.80	14.87	15.67	17.32	34.00	19.62	16.13	18.66	18.24	16.80	18.54

Please note:

- 'Buddhism' includes patients who identify as the following: Buddhist, Jain, New Kadamba Buddhist
- 'Christianity' includes patients who identify as the following: 7th Day Adventist, Anglican, Baptist, Calvinist, Catholic (Not Roman), Christadelphian, Christian, Church of England, Church of Ireland, Church of Scotland, Congregationalist, Evangelist Christian, Free Church, Jehovah's Witness, Latter Day Saints, Methodist, Mormon, Orthodox Christian, Pentecostalist, Plymouth Brethren, Protestant, Presbyterian, Quaker, Reformed Christian, Roman Catholic, Salvation Army Member, Unitarian, United Reform
- 'Eastern Orthodox' includes patients who identify as the following: Greek Orthodox, Romanian Orthodox, Serbian Orthodox
- 'Hinduism' includes patients who identify as the following: Hindu
- 'Judaism' includes patients who identify as the following: Jewish
- 'Muslim' includes patients who identify as the following: Baha'i, Islamic, Ismaili Muslim, Muslim
- 'Non-Theistic' includes patients who identify as the following: Agnostic, Atheist, Humanist, None
- 'Other' includes patients who identify as the following: Other
- 'Sikhism' includes patients who identify as the following: Sikh
- 'Spiritualism' includes patients who identify as the following: Druid, Pagan, Spiritualist, Wiccan
- 'Unknown' includes patients who identify as the following: Unknown, Religion Withheld

- 63.6% of discharged patients identify as 'Christian' compared to 25% of population according to 2021 census
- 3.9% of discharged patients identify as 'Muslim' compared to 23% of population according to 2021 census
- 7.1% of discharged patients identify as 'Hindu' compared to 18% of population according to 2021 census
- 2.1% of discharged patients identify as 'Sikh' compared to 4% of population according to 2021 census
- 9.9% of discharged patients identify as 'non-theistic' compared to 23% of population according to 2021 census

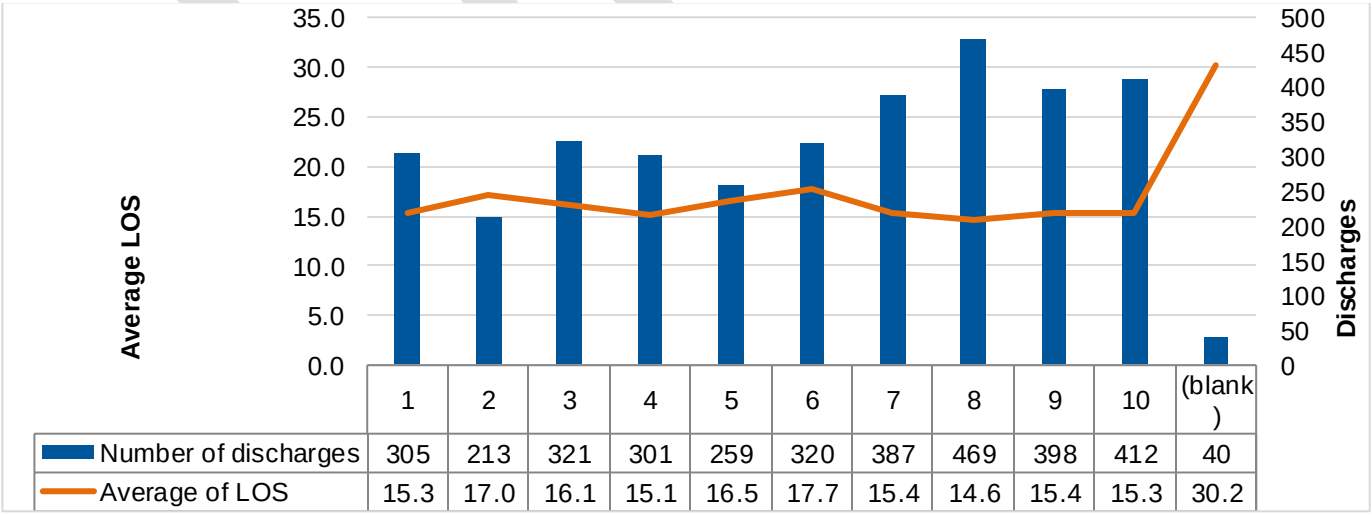
Average LOS and Number of discharges by Age Group



	10-19	20-29	30-39	40-49	50-59	60-69	70-79	80-89	90-99	100-109
Number of Discharges	7	20	39	74	175	380	886	1331	506	7
Average LOS	43.71	10.75	13.64	21.93	22.38	17.06	16.14	15.06	13.59	9.57

- Largest proportion of discharged patients aged 80-89 (38.9%)
- Under 50s make up 4.1%
- Median age of Leicester 33 according to 2021 census
- Average LOS 18.5 days (15.7 for 50+)

Average LOS and Number of Discharges by IMD Decile



	1	2	3	4	5	6	7	8	9	10	(blank)
Number of discharges	305	213	321	301	259	320	387	469	398	412	40
Average of LOS	15.3	17.0	16.1	15.1	16.5	17.7	15.4	14.6	15.4	15.3	30.2

- Highest proportion of discharges came from least deprived areas (8 – 13.7%, 9 – 11.6%, 10 – 12.0% compared to 1 – 8.9%, 2 – 6.2%, 3 – 9.4%)

- Leicester was the 32nd most deprived area of 317 local authority district area based on the Indices of Multiple Deprivation 2019

Grading Criteria for Outcome 1A:

Rating	Score	Description	Evidence examples
Underdeveloped activity	0	No or little activity taking place	Organisations/systems have little or nothing in place to ensure patients with protected characteristics have adequate and appropriate access to the services they require. Feedback from patients is not acted upon. Organisations have not identified barriers facing patients.
Developing activity	1	Minimal / basic activities taking place	Data and evidence to show relevant patients with higher risks due to a protected characteristic or at risk of health inequalities (50% of those using the service) have adequate access to the service. Patients consistently report fair or good (or the equivalent) when asked about accessing services. Demonstration that the organisation has identified barriers to accessing services.
Achieving activity	2	Required level of activity taking place	Data and evidence to show relevant patients with higher risks due to a protected characteristic or at risk of health inequalities (75% of those using the service) have adequate access to the service. Patients consistently report good or very good (or the equivalent) when asked about accessing services. Demonstration that the organisation has identified barriers to accessing services.
Excelling activity	3	Activity exceeds requirements	Data and evidence to show relevant patients with higher risks due to a protected characteristic or at risk of health inequalities (98% of those using the service) have adequate access to the service. Patients consistently report very good or excellent (or the equivalent) when asked about accessing services. Demonstration that the organisation has knowledge of barriers and have changed outcomes for people who experience those barriers in accessing services.

Grading score following engagement with key stakeholders

Grading	Result
0 - Undeveloped	0%
1 - Developing	60%
2 - Achieving	40%
3 – Exceeding	0%

Table 1 – Grading scores as a percentage for Outcome 1A where ***Developing*** *is scored highest.*

Reason for scores

‘Deprived areas very overlooked, lack of deeper knowledge on the overall effects of every day, living within the health care and services at home’.

‘Practical experience has been mixed for people and groups I know or have worked with. I think a lot of needs are now being met, but things haven't always been good over recent years.’

‘As data and evidence has shown those who are with higher risks are protected and have adequate access.’

‘Got quite a lot of evidence that verifies’

Improvement actions suggested were:

1. To be able to really listen to the people's voice, many doctors and nurses have difficulties in communication (Language barriers) so can be very hard to understand at all, and our services is run by outsourcing which is having a huge knock-on effect to the actual NHS, it's the system that don't work.
2. Better communication, better planning and better support during discharge.
3. I suspect this will vary across LLR and can be a postcode Lottery - could the data be broken down into district areas or similar?
4. Understanding the barriers such as language barriers, patients with learning difficulties.

Outcome 1b: Individual patients (service user's) health needs are met

LLR

Data and evidence show that those with higher risk due to protected characteristics or at risk of inequalities have had adequate access, patients report to receiving good level of care and health needs were met. Accessibility to intermediate care is an equal rights service which hasn't demonstrated any form discrimination for those patients with protected characteristics. The service is provided as and when required.

The below data demonstrates that the patients are receiving good level of care, where a clear communication and planning is in place as well as sufficient plans in place once patients are discharged. This clearly demonstrated patients' health needs are met during the stay and post discharge.

Further work is underway to enable us to gather more comprehensive and diverse feedback to ensure any gaps are captured and resolutions are embedded as preventative measures, to eliminate risks or inequalities to those from protected characteristics.

- Whilst in hospital 65% of patients felt they were given support to maintain a good level of independence.
- Feedback suggests 66% patients say they were involved in decisions made about next steps in their care and support
- After leaving hospital 62% felt they were given information about how they would be supported once at home
- 48% say their family/friends were given sufficient information about support and next steps

- For LLR data suggests that the average LOS of stay is lower for those from minority ethnic backgrounds, and this would suggest a personalised care approach is sufficient and effectively embedded to ensure health needs are appropriately met for service users from protected characteristics and minority groups.
- Enabling service users from minority ethnic groups return home more quickly after a hospital stay with an appropriate after care plan in place for individuals to remain independent in their homes with over **65%** of service users reported that they were provided with information and good communication to develop their personalised care plan in preparation for discharge.

UHL

- UHL data suggests that the average LOS of stay is higher for those from minority ethnic backgrounds. Patients identifying as 'White' have an average LOS of 15.31 days compared to 20.01 days for all other backgrounds.
- Similarly, there are contrasts in average LOS dependant of religion, patients identifying as 'Christian' have an average LOS of 14.87 days, those identifying as 'Muslim' 19.62 days, those identifying as 'Hindu' 17.32 days, those identifying as 'Sikh' 18.24 days and those identifying as 'non-theistic' 16.13 days.
- Overall, males (16.6) had a higher length of stay than females (14.8) (using data sets above 100 discharges per month).
- Longest average LOS age groups were 40-49 (21.93) and 50-59 (22.38), which then steadily drops off for each following group.
- Married (15.50), widowed (14.51) and divorced (14.01) patients had a lower average LOS than single (17.89) patients.
- No recognisable pattern in average LOS regarding to IMD decile, with those on the scale at 1 and 10 having the same LOS (15.3).
- Overall average LOS for all patients on Pathway 1c was 15.87.

Grading criteria for outcome 1B:

Rating	Score	Description	Evidence examples
Underdeveloped activity	0	No or little activity taking place	Patients with higher risks due to a protected characteristic receive little or no support to self-manage care needs. The organisations do little or no engagement surrounding services.
Developing activity	1	Minimal/ basic activities taking place	Patients at higher risk due to a protected characteristic needs are met in a way that works for them. The organisations often consult with patients and the public to commission, de-commission and cease services provided.
Achieving activity	2	Required level of activity taking place	Patients at higher risk due to a protected characteristic needs are met in a way that works for them. The organisations often consult with patients with higher risks due to a protected characteristic to commission, designed, increase, decrease, de-commission and cease services provided. The organisations signpost to VSCE organisations and social prescribing. Personalised care is embedded into the care delivered for those with higher risks due to a protected characteristic by the organisations.
Excelling activity	3	Activity exceeds requirements	Patients at higher risk due to a protected characteristic and other groups at risk of health inequalities needs are met in a way that works for them. The organisations fully engage with patients, community groups, and the public, to commission, designed, increase, decrease, decommission and cease services provided. The organisations work in partnership with VCSE organisations to support community groups identified as seldom heard. The organisations use social prescribing, where relevant. Personalised care is embedded into the care delivered for those with higher risks due to a protected characteristic by the organisations. The organisations work with, and influence partners, to improve outcomes for people with a protected characteristic and other groups at risk of health inequalities, across the system or where services connect.

Grading score following engagement with key stakeholders

Grading	Result
0 - Undeveloped	0%
1 - Developing	80%
2 - Achieving	20%
3 – Exceeding	0%

Table 2 - *Grading scores as a percentage for Outcome 1B where **Developing** is scored highest.*

Reason for Scores

‘62 percent - patients FELT they were given the information, however nothing impacted on going forward.’

‘Had bad experiences and I am elderly’

‘The data suggests some areas for improvement’

‘From the data it shows that patients’ needs are being met, there is clear communication on next steps, what support is available etc.’

Improvement actions suggested were:

1. Seems lacking knowledge for aftercare that is put into practice, the actual level of care is not to the standards it should be or was used to. Patients feel let down, ignored and just another number for data rather than being treated like a human being.
2. Family members really need any key information on what has been supported and next steps. Again, is there any additional data breakdown, as some of the could be down to follow up care, any access barriers etc?

3. Patients of ethnic groups to have tailored support, they may not always understand what is being told due to language barriers, not understanding medical terminology, giving them more support where required.

Outcome 1c: When patients (service users) use the service, they are free from harm

LLR

Data and evidence shows that those with higher risk due to protected characteristics or at risk of inequalities have had adequate access, patients report to receiving good level of care and health needs were met and are free form harm Accessibility to intermediate care is an equal rights service which hasn't demonstrated any form discrimination for those patients from protected characteristics, service is provided as and when required, the below principles and standard operating procedures enables service users are free from harm.

LLR Intermediate care leadership have developed various principles to ensure service users are free from harm:

- Work and deliver intermediate care in a collaborative way that optimises independence and wellbeing
- Adaptation of a person-centred approach, taking into consideration cultural differences, disabilities and personal preferences. Adhering appropriately to LLR equality, equity and diversity policies and developing processes to eliminate risks or discrimination.
- Explication engagement across all stages of assessment and delivery, ensuring good communication, and elimination of any barriers between intermediate care practitioners and service users and their families and carers
- Ensuring that the person using intermediate care, their family and carers know who to speak to if they have any questions or concerns about the service, and how to contact them.
- Risk assessments are conducted at each welcome visit, all staff complete health and safety training and provide risk assessments to all carers for each activity.
- Home Care Assessment & Reablement Team HART provides the service user with a welcome pack and a service user guide. A satisfaction form is inserted with pre-paid envelope. Service user guide

provides information regarding the complaint's procedure and the contact details of the registered manager.

- HART conduct a Q & A with service user towards the end of our service.

To eliminate language, speech, cultural barriers intermediate care offer's service users' various methods and approaches to enable them to sufficiently make decisions about their care and support and be confident, independent and comfortable with the information provided, whilst in hospital or during the after-care planning. Information is offered range of accessible formats, for example:

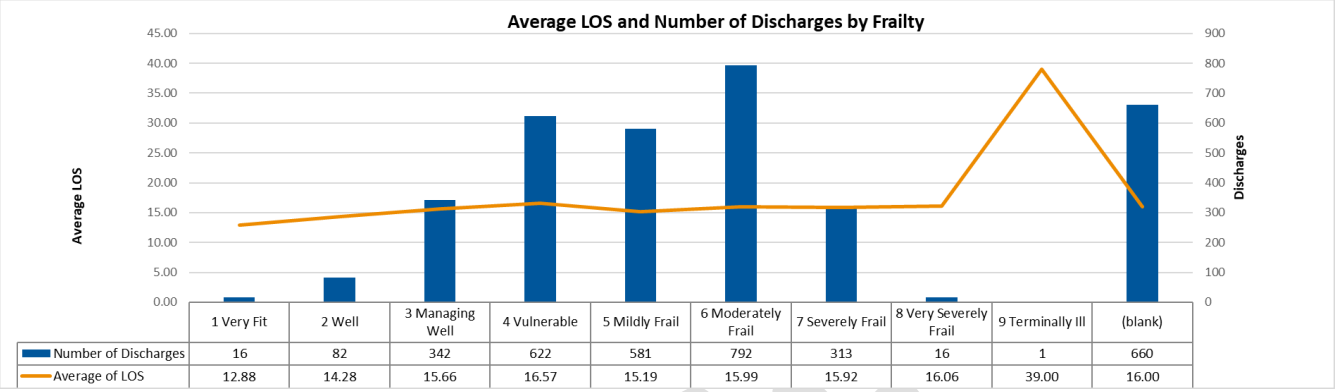
- Verbally
- In written format (in plain English)
- In other accessible formats, such as Braille or Easy Read, larger fonts
- Translation into other languages
- Interpretation in appropriate languages.

UHL

UHL has several policies in place to protect patients from harm regarding protected characteristics, safeguarding and patient safety:

- Mental Capacity Act training and procedures
- Trust wide EDI strategy
- Patient Safety Incident Response Framework strategy
- Disability policy
- Safeguarding strategy
- Deprivation of Liberty safety standards
- Discharge and transfer of care policy.
- Altered behavior policy.
- Nutrition and hydration policy
- Consent to examination or treatment policy.
- Dentition of patients under the Mental Health Act policy
- End of Life care children and adults
- Ligature risk reduction policy.
- Learning Disabilities and Autism UHL Emergency Department Guideline
- Medication errors policy
- Missing patients' policy
- Rapid flow /outlier's policies

- Restrictive interventions policy



	1 Very Fit	2 Well	3 Managing Well	4 Vulnerable	5 Mildly Frail	6 Moderately Frail	7 Severely Frail	8 Very Severely Frail	9 Terminally Ill	(blank)
Number of Discharges	16	82	342	622	581	792	313	16	1	660
Average of LOS	12.88	14.28	15.66	16.57	15.19	15.99	15.92	16.06	39.00	16.00

- Little significant impact on average LOS due to Frailty score suggests those requiring higher levels of care to ensure patient safety are receiving it.
- Frailty scores used were recorded at the start of the patients' stay.
- Scores are typically given to patients above the age of 65.

UHL also refers to inclusivity as one of the 4 Core Values of the Trust. To achieve this UHL strives to:

- Create a safe space for people of all communities
- Tackle health inequalities through the Health Equality Partnership
- Run workshops for staff around Cultural Safety led by Director of Health Equality and Inclusion (EDI)
- Highlight individual patient experiences around EDI through internal forums
- Find new ways of working to be inclusive including a translated video service in partnership with the local Health Innovation Network
- Use data from patient experience surveys to lead improvement programmes
- Work closely with community leaders and partner organisations to understand the local picture and take action.

Grading criteria for outcome 1C:

Rating	Score	Description	Evidence examples
Underdeveloped activity	0	No or little activity taking place	The organisation may or may not have mandated/ basic procedures/initiatives in place to ensure safety in services. Staff and patients are not supported when reporting incidents and near misses. The organisation holds a blame culture towards mistakes, incidents and near misses.
Developing activity	1	Minimal / basic activities taking place	The organisation has mandated/ basic procedures/initiatives in place to ensure safety in services. The organisation has procedures/initiatives in place to enhance safety in services for patients in protected characteristic groups.
Achieving activity	2	Required level of activity taking place	The organisation has procedures/initiatives in place to enhance safety in services for patients in all protected characteristic groups where there is known H&S risks. Staff and patients feel confident, and are supported to, report incidents and near misses. The organisation encourages an improvement culture giving consideration to equality and health inequality themes in safety incidents and near misses.
Excelling activity	3	Activity exceeds requirements	The organisation has procedures/initiatives in place to enhance safety in services for all patients in protected characteristic groups where there is known H&S risks. Staff and patients are supported and encouraged to report incidents and near misses. The organisation encourages and promotes an improvement culture actively including equality and health inequality themes in safety incidents and near misses. The organisations work with system and community partners to improve safety outcomes for people, using existing data and driven by service need/risk.

Grading	Result
0 - Undeveloped	0%
1 - Developing	20%
2 - Achieving	**80%**
3 – Exceeding	0%

Table 3 - Grading scores as a percentage for Outcome 1C where Achieving is scored highest.

Reason for Scores

'Mainly the elderly have concerns when using the service but also show high levels of assistance needed for them in hospital that can cause harm to others.'

'Room for improvement to access needs - once access is received service and support is great.'

'Evidence suggests this is being achieved, but I would like to see more evidence.'

'There are robust strategies and policies in place to keep patients safe from harm. Staff understand patients' backgrounds whether cultural or not and they are protected.'

Improvement actions suggested were:

1. Wards for the elderly, separate and bring back morals, high standards and have people paid in the job because they care, not just because it pays the bills.
2. Long waits to access care, ambulance wait times are terrible, hard to make contact with services.
3. I would ask whether family members and carers are there to support more frail or vulnerable users when being questioned? Is there any further information on additional support needs people have?

Outcome 1D Patients (service users) report positive experiences of the service

The 'Voice of the Person Activity' was carried out in July 2023 and involved a series of telephone and some face-to-face interviews conducted by practitioners in Leicester City and Leicestershire. With the target audience being individuals who had recently been through the Discharge process interviews were conducted either with (themselves or family members/carers) to enable us to understand their experiences.

Following provides an overview and both positive and negative experiences received by patients and service users.

- Further Voice of the Person activity is underway and findings to be published June 2025, this shall then provide us with further insight on individuals experiences during their discharge process to enable us to sufficiently eliminate any gaps, risks or operational issue that patients may have experienced.

- Its fundamental for us to get honest and transparent views on the service you or your family member may have experienced during your/their discharge experience from hospital to your/their home. This can be including the aftercare once you are in your home.
- Any suggestions and thought on future improvements are also very welcomed either utilising the chat box or feedback forms which have been provided to you and can be access via this link: https://forms.office.com/e/bD4hMcG2yt

The staff were amazing they looked after me so well and were always coming over to talk to me which was nice.
Leicester City Resident, Discharged onto Pathway 1

Care was very professional from the doctor and nurses; they organised scans and Xray and always kept me informed about each step.
Leicestershire Resident, Discharged onto Pathway 1

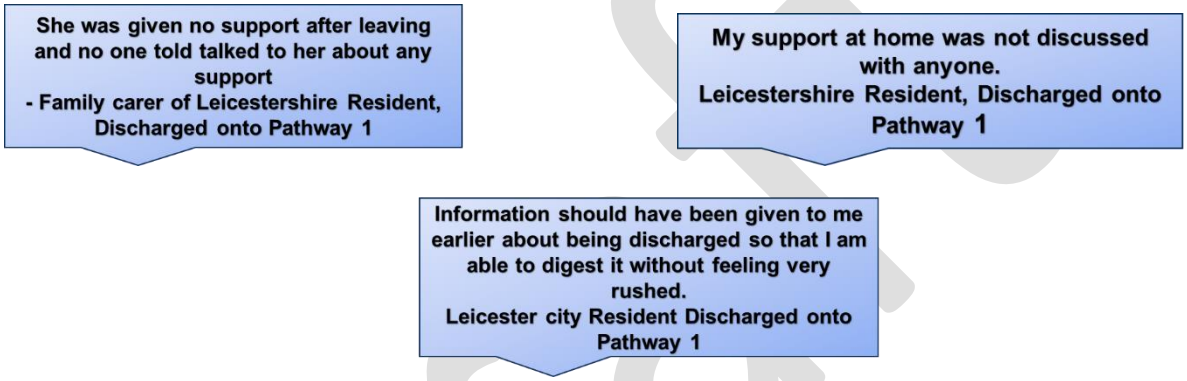
- Whilst in hospital **65%** of patients felt they were given support to maintain a good level of independence.
- Once patients were discharged **48%** felt the support, they received helped them to recover, regain their independence, and enabled them to return to normal daily living prior to hospital stay.
- **44%** of patients say once their hospital treatment had finished, they were discharged as quickly as they wanted to be.
- Feedback suggests **66%** patients say they were involved in decisions made about next steps in their care and support
- After leaving hospital **62%** felt they were given information about how they would be supported once at home
- **48%** say their family/friends were given sufficient information about support and next steps
- Feedback suggests **31%** of carers were provided with sufficient information how they would be supported after hospital discharge

UHL

Discharge Satisfaction Question	Trust	CHUGGS	EM	ITAPS	MSS	RRCV	SM	W&C
Did you feel you were involved in decisions about your discharge from hospital?	81.7	81.6	71.6	98.7	86.0	80.7	76.5	86.4
Was your discharge delayed for any reason?	72.5	72.0	70.4	-	78.4	68.0	68.4	75.0
Were you given any written or printed information about what you should or should not do after leaving hospital?	74.8	78.1	60.1	-	90.9	83.0	61.8	88.9

- Patients' average satisfaction score regarding to being involved in decisions for their own care at **81.7**
- Patients' average satisfaction score regarding experiencing discharge delays at **72.5**
- Patients' average satisfaction score regarding being provided the correct information following discharge at **74.8**

Negative experiences LLR



- Whilst in hospital **28%** of patients felt they were **Not** given enough support to maintain a good level of independence.
- Once patients were discharged **38%** felt the support, they received **Did Not Help** them to recover, regain their independence, **nor** enabled them to return to normal daily living prior to hospital stay.
- **48%** of patients say once their hospital treatment had finished, they were **Not** discharged as quickly as they wanted to be.
- Feedback suggests **38%** patients say they were **Not** involved in **Any** decisions made about next steps in their care and support.
- After leaving hospital **48%** felt they were **Not** given information about how they would be supported once at home.
- **17%** say their family/friends were **Not** given sufficient information about support and next steps.
- Feedback suggests **27%** of carers were **Not** provided with sufficient information how they would support after hospital discharge

UHL

Discharge Satisfaction Question	Trust	CHUGGS	EM	ITAPS	MSS	RRCV	SM	W&C
Was your discharge delayed for any reason?	72.5	72.0	70.4	-	78.4	68.0	68.4	75.0
How long was the delay?	21.5	19.9	27.1	-	26.6	23.9	18.8	24.8

- For those patients that did experience a delay in discharge, satisfaction scores around the length of the delay were very low.
- Certain Clinical Medical Groups scored low on all questions – improvement projects ongoing to rectify this.

Key:

- CHUGGS – Cancer, Haematology, Urology, Gastroenterology and Gastro-Intestinal Surgery
- EM – Emergency Medicine
- ITAPS – Intensive Care, Theatres, Theatre Arrivals, Pain and Sleep
- MSS – Musculoskeletal and Specialist Surgery
- RRCV – Renal, Respiratory and Cardiovascular
- SM – Specialist Medicine
- W&C – Women's and Children's

Grading criteria for Outcome 1D:

Rating	Score	Description	Evidence examples
Underdeveloped activity	0	No or little activity taking place	The organisations do not engage with patients about their experience of the service. The organisations do not recognise the link between staff and patient treatment. The organisations do not act upon data or monitor progress.
Developing activity	1	Minimal / basic activities taking place	The organisations collate data from patients with protected characteristics about their experience of the service. The organisation creates action plans, and monitors progress.
Achieving activity	2	Required level of activity taking place	The organisations collate data from patients with protected characteristics about their experience of the service. The organisations create evidence-based action plans in collaboration with patients and relevant stakeholders, and monitors progress. The organisation shows understanding of the link between staff and patient treatment and demonstrate improvement in patient experiences.
Excelling activity	3	Activity exceeds requirements	The organisation actively engages with patients with protected characteristics and other groups at risk of health inequalities about their experience of the service. The organisation actively works with the VCSE to ensure all patient voices are heard. The organisations create data driven/evidence-based action plans, and monitors progress. The organisation shows understanding of the link between staff and patient treatment. The organisations use patient experience data to influence the wider system and build interventions in an innovative way.

Grading score following engagement with key stakeholders

Grading	Result
0 - Undeveloped	0%
1 - Developing	80%
2 - Achieving	20%
3 – Exceeding	0%

*Table 4 - Grading scores as a percentage for Outcome 1D where **Developing** is scored highest.*

Reasons for Scores

‘Most areas were happy somewhat when receiving hospital treatment, aftercare and lack of practice and knowledge needs improvement.’

‘Some part of service is very positive others are not’.

‘The evidence suggests key areas for improvement.’

‘Most patients have said they feel well supported, they are able to be included in making decisions in their care plan, family feel well informed.’

‘My experience was not very good.’

Improvement actions suggested were:

1. Shocked at this data. We should have the most amazing health care in the world. I personally would like to see ALL these numbers at least 80-90 percent satisfaction overall these areas should be hitting good feedback and responses, we are failing at healthcare full stop. Action needs taking before the demise of our structure as a whole.

2. My care was good in hospital and staff were great but once I was discharged I had very little support.
3. Particularly concerned about the response from carers - they really need support in their carer roles.
4. The patients who have not felt the same regarding getting that same level of care. How to make that experience better.

Additional Feedback received.

Key findings LLR

- 15% of LLR service users were re-admitted during the diagnostic period.
- Data and evidence show that those with higher risk due to protected characteristics or at risk of inequalities have adequate access, patients report to receiving good level of care and accessibility to the service.
- Majority of the service users during the diagnostic period were between 65-103 years of age (88%), this is very much aligned with frailty and the growing aging population.
- 12% of the service users were under 64 (18-64 years of age)
- Both the male and female population split from non- minority ethnic groups had an average of 3 days of length of stay.
- Those from a minority ethnic groups average length of stay of 2 days both for Male and Female.
- Sufficient risks assessments are in place to ensure service users are free from harm.
- Patients report positive engagement
- Further evaluation will take place from this engagement event to ensure we are developing and aligning next steps in terms of feedback and grading provided from these two engagement events.

Key Findings UHL

- Protected characteristics suggest a significant impact on LOS – those from ethnic or religious minority backgrounds face a longer average stay
- Number of discharges for some characteristics unlike what was expected in relation to area population data
- Higher number of instances coming from the least deprived areas
- Policies are in place to protect patients from harm
- Patients report mostly positive experiences, negative experiences around delays to be looked at
- Overall average LOS 15.87 days

Next Steps LLR

Key Improvements priorities:

- Further work is underway to enable us to gather more comprehensive and diverse feedback to ensure any gaps are captured and resolutions are embedding as preventative measure, to eliminate risks or inequalities to those from protected characteristics.
- Improve on how data is collated to ensure we are capturing to enable us to eliminate any risks
    - Ethnic groups/Religion/belief
    - Sex,
    - Disability,
    - Marital status
    - Age
    - Specific discharge speciality
    - Sexual orientation
- Develop a Standard Operating Procedure SOP/ Framework to provide explicit service overview to enable us to remove any risks or barriers service users may face, this would also support us to sufficiently carry out frequent evaluations and determine any risks/gaps and rectify as soon as possible.

Key Improvements priorities:

- Individuals service user's feedback/ experiences to be collated at either time of stay, time of discharge or thereafter to enable us to regularly review, prevent and eliminate risks or inequalities to those from protected characteristics focusing on the below outcomes alongside any additional feedback whether this be a positive or negative experience.
    a) Patients (service users) have required levels of access to the service
    b) Individual patients (service user's) health needs are met
    c) When patients (service users) use the service, they are free from harm
    d) Patients (service users) report positive experiences of the service
    e) Develop reporting and grading findings from the engagement events with sufficient evidence to senior leadership team and intermediate care board alongside an EDI and improvement plan.

- Meeting to be arranged with Intermediate Care leads to discuss findings and ways to embed improvements to eliminate any risk or discrimination.
- Further feedback from service users is currently being collated via health watch.

Next Steps UHL

Improvements changes to be embedded:

- Report findings of this study to senior leadership team and work with EDI leads to plan for improvements.
- Investigate the cause of delays for discharge and how we can reduce the number of instances.
- Ensure patients have the correct access to the services they require.
- Certain CMGs (Clinical Management Groups) scored low on all patient experience questions – improvement projects ongoing to rectify this.

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