

**Reference:** FOI.ICB-2627/029

**Subject:** Next Steps for Frenchay Hospital Site

*I can confirm that the ICB does hold some of the information requested; please see responses below:*

| QUESTION   | RESPONSE  |
|--|---|
| <p>Please provide the evidence base underpinning the report titled "Next steps for Frenchay Hospital site" presented to South Gloucestershire Health Scrutiny Committee on 1st April 2026.</p>   |   |
| <p>1. Discharge to Assess Programme Outcomes</p> <p>Please provide any recorded data, reports or summaries (2022-2025) used to support the statements that the programme has:</p> <ul style="list-style-type: none"> <li>• Reduced demand for bedded rehabilitation;</li> <li>• Shortened hospital length of stay;</li> <li>• Increased delivery of rehabilitation at home.</li> </ul> | <p><b>Reduced demand for Bedded Rehabilitation:</b></p> <ul style="list-style-type: none"> <li>• Across BNSSG there has been an 8% decrease in patients being discharged into community beds, between 2022/23 and 2025/26</li> </ul> <p><b>Shortened Hospital Length of Stay (LoS)</b></p> <ul style="list-style-type: none"> <li>• The average hospital length of stay for patients discharged into a community rehabilitation bed reduced by 8 days between 2022/23 to 2025/26.</li> </ul> <p><b>Increased delivery of rehabilitation at home</b></p> |

- Across BNSSG, pathway improvements and community investment has led to a 34% increase in people being discharged home with a package of care, between 2022/23 and 2025/26.

| <b>Discharges (Full Year)</b>                 | <b>Home with package of care</b> | <b>Community bed</b> |
|---|----------------------------------|----------------------|
| 2022/23                                       | 6003                             | 3083                 |
| 2023/24                                       | 6739                             | 2781                 |
| 2024/25                                       | 8108                             | 2817                 |
| 2025/26                                       | 8035                             | 2839                 |
| Percentage change between 2022/23 and 2025/26 | 33.8%                            | -7.9%                |

| <b>Average LoS in days</b>          |                      |
|-------------------------------------|----------------------|
| <b>Discharge location</b>           | <b>Community bed</b> |
| 2022/23 average                     | 38.3                 |
| 2023/24 average                     | 29.7                 |
| 2024/25 average                     | 29.6                 |
| 2025/26 average (up to December-25) | 30.2                 |

## 2. Evaluation Reports

Copies of any evaluations, internal reports, or analyses assessing the effectiveness of home-based rehabilitation or Discharge to Assess pathways in BNSSG.

The BNSSG strategic approach for developing home based intermediate care services is based on national research and best practice. Key documents which provide a synthesis of this information are:

|   |   |
|---|---|
|   | <p>NICE Guideline 74 – Intermediate Care including reablement (<a href="https://www.nice.org.uk/guidance/ng74">https://www.nice.org.uk/guidance/ng74</a>)</p> <p>NHS England Intermediate Care Framework (2023)<br/><a href="https://www.england.nhs.uk/wp-content/uploads/2023/09/PRN00761-intermediate-care-framework-rehabilitation-reablement-recovery-following-hospital-discharge.pdf">https://www.england.nhs.uk/wp-content/uploads/2023/09/PRN00761-intermediate-care-framework-rehabilitation-reablement-recovery-following-hospital-discharge.pdf</a></p>   |
| <p>3. Rehabilitation Bed Modelling</p> <p>Any documents describing the methodology used to estimate a requirement of 130- 150 rehabilitation beds, including:</p> <ul style="list-style-type: none"> <li>• modelling assumptions;</li> <li>• input data sources;</li> <li>• any sensitivity testing or scenario analysis (if held)</li> </ul> | <p>The model used is a Systems Dynamics model, a mathematical modelling tool using ‘stocks and flows’ methodology.</p> <p>The model uses the number of admissions to hospital as its starting point and flows patients based on proportions through discharge and into community services. It can be used to determine need at each stage of a patients journey through the acute into intermediate services and beyond.</p> <p>Acute, community provider and Local Authority aggregated data is used as input sources.</p> <p>Assumptions included length of stay changes being achieved by end of modelled time frames and pathway shifts between different D2A pathways having been achieved</p> |
| <p>4. Equality and Health Inequalities Impact Assessment (EHIA)</p>   | <p>Please find enclosed.</p>  |

|   |  |
|---|--|
| <p>The full EHIA referenced in the report, together with any supporting data or analysis used to assess impact on protected groups.</p>   |  |
| <p>5. Cognitive Impairment/Dementia</p> <p>Any recorded analysis, data, or guidance relating to the effectiveness or suitability of home-based rehabilitation for patients with cognitive impairment or dementia.</p> | <p>The ICB does not hold any specific analysis or data regarding the effectiveness of home-based rehabilitation for patients with cognitive impairment or dementia.</p> <p>A range of national publications and research supports home based rehabilitation and is also applicable for people with dementia and cognitive impairment, emphasising personalisation and integration into a patient’s familiar environment to maximise functional independence.</p> <p>Some key documents which support this approach are:</p> <p>National Institute for Health and Care Excellence. (2018). <i>Dementia: assessment, management and support for people living with dementia and their carers</i> (NICE Guideline NG97).<br/><a href="https://www.nice.org.uk/guidance/ng97">https://www.nice.org.uk/guidance/ng97</a></p> <p>NICE Quality Standard [QS184]: Dementia<br/><a href="https://www.nice.org.uk/guidance/qs184">https://www.nice.org.uk/guidance/qs184</a></p> |
| <p>6. Performance Metrics</p> <p>Any documents describing key performance indicators (KPIs), outcome measures, or monitoring frameworks used to assess home-based rehabilitation services.</p>                        | <p>These are the KPIs which the ICB receives from commissioned community services.</p> <p>Note: the Pathway 1 is defined as the discharge of a patient to their home or usual place of residence.</p>  |

|   |  |
|---|--|
|   | <ul style="list-style-type: none"> <li>• Pathway 1 referrals sent / received</li> <li>• Pathway 1 waiting list, and slots booked and utilised</li> <li>• Pathways 1 active caseload</li> <li>• Pathway 1 numbers of discharges and average length of stay in the P1 service</li> <li>• Pathway 1 slots booked and utilised</li> <li>• Pathway 1 Average Length of Stay</li> <li>• Discharge Outcomes after the P1 period (e.g. Home or hospital readmission)</li> </ul>  |
| <p>7. Operational Definitions</p> <p>Any recorded documents defining or describing:</p> <ul style="list-style-type: none"> <li>• "clinically led eligibility and stratification";</li> <li>• "reasonable adjustments" in this context;</li> <li>• Support arrangement for informal carers within home-based rehabilitation pathways.</li> </ul> | <ul style="list-style-type: none"> <li>• <b>Clinically Led Eligibility and Stratification</b><br/>The ICB does not hold this information. The clinical teams who assess patient's eligibility for either home based or bedded rehabilitation are based in our acute Trusts.<br/><br/>This information should be requested from North Bristol NHS Trust (NBT) and University Hospitals Bristol and Weston NHS Foundation Trust (UHBW):<br/><br/><a href="mailto:FOIArequests@nbt.nhs.uk">FOIArequests@nbt.nhs.uk</a><br/><a href="mailto:FreedomOfInfo@uhbw.nhs.uk">FreedomOfInfo@uhbw.nhs.uk</a></li> <li>• <b>Reasonable adjustments</b><br/>The ICB does not hold this information. The clinical teams who assess and implement any reasonable adjustments to support home-based care are based in our community care provider.</li> </ul> |

This information should be requested from Sirona Care and Health: [Sirona.hello@nhs.net](mailto:Sirona.hello@nhs.net)

- **Support arrangements for information carers within home-based rehabilitation pathways**

South Gloucestershire Council commission Carers Support to provide Hospital Carer Liaison Workers. The service offers practical and emotional support to carers during a hospital stay and at the point of discharge. This includes assistance with accessing hospital services, advice related to the caring role, support with communication between carers and health professionals, and advocacy in meetings such as care planning or discharge planning. Hospital Carer Liaison Workers can also explain hospital processes, provide information on financial support and welfare benefits, advise on the process for a Carer's Assessment and support carers to arrange one where appropriate, and signpost to local carer services. Council's have a legal duty to assess any carer who requests an assessment or appears to have support needs – even if the cared for person refuses their own assessment.

If the carer meets the national eligibility criteria the council has a duty to meet the carer's needs for support in their caring role. Support may be provided directly to the carer for example through information and advice, wellbeing support, training or a Direct Payment. Support may be provided indirectly to the carer

|  |  |
|--|--|
|  | via care for the cared for person for example replacement care at home which enables the carer to take breaks from caring. |
|--|--|

***The information provided in this response is accurate as of 20 May 2026 and has been approved for release by David Jarrett, Chief Strategic Commissioning Officer for NHS Bristol, North Somerset and South Gloucestershire ICB.***

## BNSSG ICB Gateway Process – Gate 1 Documentation

### Equality & Health Inequality Impact Assessment

Other documents required to complete the Equality & Health Inequality Impact Assessment:

- [Equality & Health Inequality Impact Assessment Guidance](#)
- [Equality & Health Inequality Impact Assessment Resources](#)

**Please ensure you read the guidance and resources in full before attempting to complete this template.**

|  |  |   |   |  |
|--|--|---|---|--|
| Title of proposal: End plans to develop a bedded rehabilitation facility Frenchay site   |  |   |   | Date: 16 <sup>th</sup> February 2026   |
| <input type="checkbox"/> Policy  | <input type="checkbox"/> Strategy                  | <input checked="" type="checkbox"/> Service | <input type="checkbox"/> Function                       | <input type="checkbox"/> Other (please state)  |
| EHIA type:   | Screening EHIA <input checked="" type="checkbox"/> | Full EHIA <input type="checkbox"/>          | HEAT in progress/<br>completed <input type="checkbox"/> | Has an EHIA been previously undertaken?<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| Is the policy under:   | Development <input checked="" type="checkbox"/>    | Implementation <input type="checkbox"/>     | Review <input type="checkbox"/>                         |  |
| Which groups will this service/proposal impact (e.g. patients, service users, carers/family, staff, general public, partner organisations)? Patients, Users, Carers, Staff, General public, partners |  |   |   |  |
| Lead person(s) completing this assessment: Andy Newton   |  |   |   |  |
| Lead person job title(s) and service area: Head of Integrated Care   |  |   |   |  |

### Step 1: Outline

#### 1.1 Briefly describe the proposal

Give a brief description of the context, purpose, aims and objectives of the proposal. Describe what services are currently being provided. Describe the intended outcomes and benefits and who these might impact. Include whether it is a new proposal or change to an existing one and the key decision that will be informed by the EHIA (e.g. whether or not to proceed with the proposal to publish an employee handbook)

Following the closure of Frenchay Hospital in 2014, the NHS committed to developing a rehabilitation facility on the site. This commitment has continued to attract public interest and campaigning. Changes in national policy and local service models have altered the requirement for additional bedded rehabilitation capacity. It is proposed that there is no longer a strategic need for a rehabilitation facility on the Frenchay site. In addition, building a new site is also not financially viable or a capital funding priority.

This proposal is not a change to an existing service, and it is not a proposal to start a new service. If approved, the proposal will end plans for a new rehabilitation centre on Frenchay site. The EQIA requirement is reviewing the impact of the changes over recent years in developing home first services, which mean that a rehabilitation centre is not required on this site

In 2014 NHS leaders committed to developing a new rehabilitation facility on the site, including 68 inpatient beds for post-acute and community recovery. However, plans for a community hospital were formally withdrawn in 2013, prompting public concern and sustained campaigning.

Following external reviews, the D2A programme in 22/23 24/25 coordinated over £13 million of additional investment in community services. The programme aimed to support discharge home with appropriate care, reduce hospital length of stay and decrease reliance on bedded rehabilitation.

Enhancements included investment in the voluntary sector to support discharge, additional community therapy staff, overnight support, expanded local authority reablement services, greater use of technology-enabled care, and improved multidisciplinary working.

By the end of 2024, the programme had successfully increased the delivery of rehabilitation and reablement at home, reduced demand for bedded community care, and shortened hospital stays prior to discharge.

BNSSG modelling demonstrates that the ICB is currently commissioning an appropriate level of bedded rehabilitation capacity. Relocation of existing rehabilitation facilities to a new site is not a requirement or a priority.

Health inequalities (HI) are systematic, avoidable and unjust differences in health and wellbeing between different groups of people. Reducing health inequalities improves life expectancy and reduces disability across the social gradient. What health inequalities have or might emerge and what actions can you take to reduce or eliminate them? Include details of any evidence, research or data used to support your work, e.g. JSNA, ward data, meeting papers, NICE etc below. You can also consider completing the [HEAT tool](#) to support summarising key issues, this can help to systematically evaluate HI:

This assessment is focussed on the impact of not proceeding with plans for a rehabilitation centre on the Frenchay site.

By not proceeding with the Frenchay site plans, services continue to develop with a home first approach to rehabilitation and reablement wherever possible.

The people who will be impacted by a decision to not proceed with the Frenchay Rehabilitation plans are people who are discharged from hospital for rehabilitation. In focussing on home first services and not increasing the capacity of bedded rehabilitation facilities, the following conditions might impact on health inequalities:

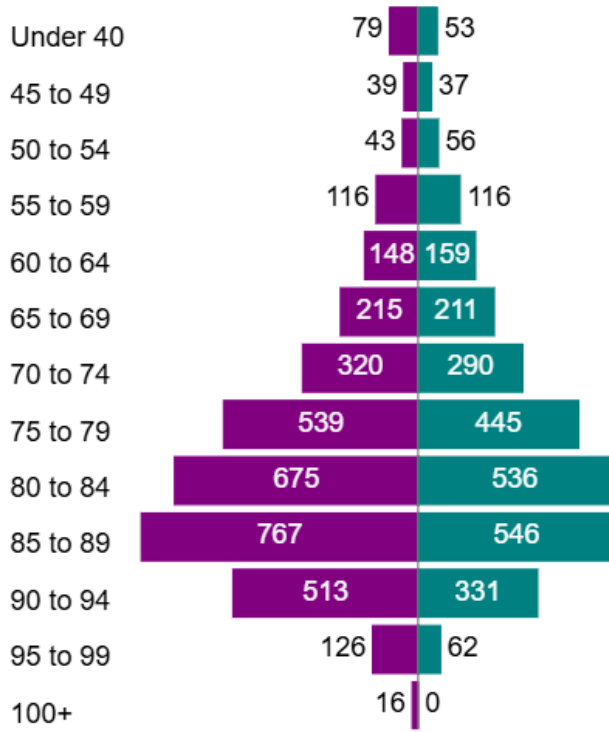
1. more people will receive rehabilitation at home instead of in a bedded unit
2. people will continue to be transferred from hospital to existing rehabilitation units, instead of being discharged to a new centre on the Frenchay site.

The following information is available on age, gender and ethnicity for patients who are discharged into home based rehabilitation / reablement (called P1) or bed based rehabilitation (called P2).

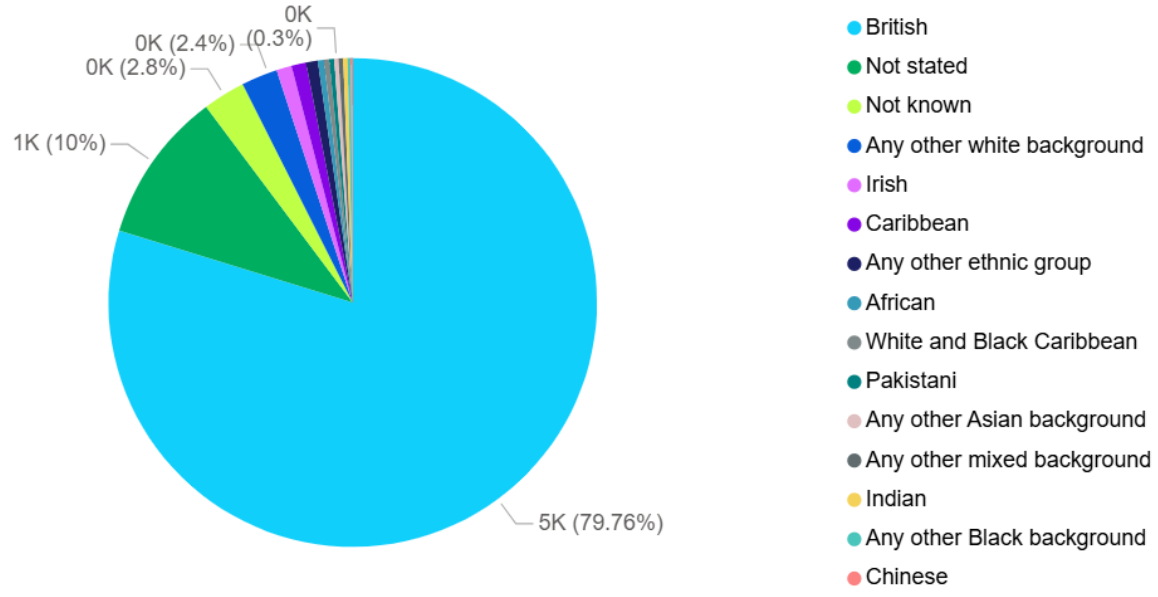
## Pathway 1

### Discharges by Age Band and Sex (P1)

● Female ● Male



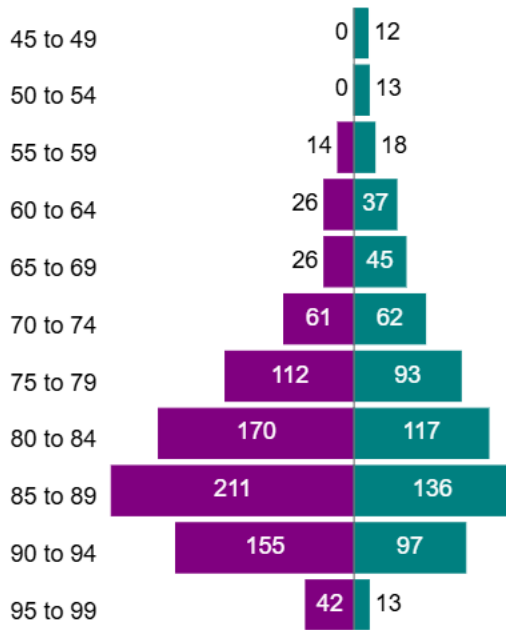
Discharges by Ethnicity Category (P1)



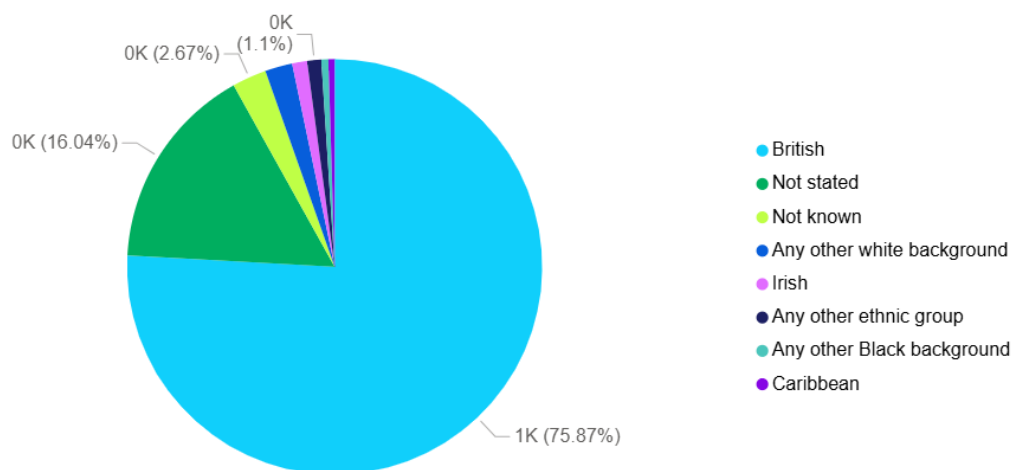
## Pathway 2

### Discharges by Age Band and Sex (P2)

● Female ● Male



Discharges by Ethnicity Category (P2)



### Impact of moving to a more home based rehabilitation model

Give details of any relevant patient experience data or engagement that supports your work and where there is significant impact and major change how have patients, carers or members of the public been involved in shaping the proposal. Note, where the proposed change results in significant variation public consultation is required, seek advice from your PPI team. If you have not undertaken any engagement, state how you will involve people with protected characteristics or vulnerable groups in the project or explain why there is not likely to be any involvement.

The proposal does not impact or change current services. A full communications and engagement plan has been developed, which sets out a structured approach for communicating and engaging with stakeholders and the public regarding the proposal to formally end plans to develop a bedded rehabilitation facility on the Frenchay site. The plan aims to ensure that communication is transparent, evidence-based and responsive to public interest, while meeting statutory consultation and engagement expectations and maintaining public trust. The key audience includes:

- Local councillors
- Interested residents of South Gloucestershire and surrounding communities
- Local media, particularly those that have actively reported on Frenchay in recent years (e.g. Voice Series, Gazette Series, Bristol Live).
- Healthwatch/ patient groups / VCSE groups with a particular interest

Where possible and appropriate, activities will be undertaken in partnership with South Gloucestershire Council and North Bristol NHS Trust. This includes:

- Written briefing materials (e.g. stakeholder letter, Health Overview and Scrutiny Committee (HOSC) papers)
- Stakeholder discussions (e.g. private one-to-ones or public forums such as HOSC)
- Community information event
- Media briefings
- Press releases or proactive statements
- Website/ intranet updates.

Has the project/service ensured that they have/will comply with the Accessible Information Standards (AIS)? Yes or No  
 Describe how the project/service will ensure staff are in compliance and have a consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents, where those needs relate to a disability, impairment or sensory loss.  
 For more information on AIS please refer to and [NHS England » Accessible Information Standard](#) and [AIS at NBT - YouTube](#).

Current rehabilitation services are compliant with Accessible Information Standards as part of ICB commissioned services. This proposal does not cause any changes to this.

## Step 2: Impact

### 2.1 Could the proposal have a positive or negative impact on any of the protected characteristic groups or other relevant groups?

Although some of your conclusions will be widely known and accepted (e.g. need for accessible information), your analysis should include evidence to support your statements to aid the decision-maker – references and links to documents can be listed in section 4.1. Evidence might include insights from your engagement, focus groups, stakeholder meeting notes, surveys, research paper, national directives, expert opinion etc. If there is insufficient evidence, state this and include an action to find out more in the action plan in Step 3. In addition to having due regard for the Equality Act 2010 Public Sector Equality Duty to eliminate unlawful discrimination, advance equality and foster good relationship between protected groups; you must also have due regard to the principles of the Armed Forces Act 2021 including regarding the unique obligations and sacrifices they make, removing disadvantage and making special provision to ensure services and employment opportunities are accessible.

| Positive Impact:             |  |   |  |  |
|------------------------------|--|---|--|--|
| <input type="checkbox"/> Sex | <input type="checkbox"/> Race                  | <input type="checkbox"/> Disability                   | <input type="checkbox"/> Religion & Belief   | <input type="checkbox"/> Sexual Orientation  |
| <input type="checkbox"/> Age | <input type="checkbox"/> Pregnancy & Maternity | <input type="checkbox"/> Marriage & Civil Partnership | <input type="checkbox"/> Gender Reassignment | <input type="checkbox"/> Armed Forces<br><input type="checkbox"/> Other health inequality (please state below) |

Provide a narrative about the benefits including benefits to any of the protected characteristic groups plus health inequality groups (such as digital exclusion). Also include intersectional impact where possible here:

Not building a new rehabilitation centre on the Frenchay site supports the system strategy for home first rehabilitation and reablement. Home first approach supports improved outcomes for patient requiring rehabilitation, many of whom are elderly. A home first approach supports independent living, enabling recovery at home and reducing the likelihood of people needing long term admission to care homes.

The transition from bedded rehabilitation to home-based rehabilitation has the potential to deliver significant equality benefits when designed and implemented inclusively. For many individuals across protected characteristic groups, receiving rehabilitation in their own home may reduce barriers to access, improve engagement, and enhance outcomes.

### **Age**

For older people, home-based rehabilitation may reduce the risks associated with prolonged hospital stays, including deconditioning, hospital-acquired infection, and delirium. Rehabilitation delivered in a familiar home environment can improve confidence, functional independence, and relevance of therapy to daily living tasks. For working-age adults, home-based models may provide greater flexibility to schedule therapy around employment or caring responsibilities, supporting faster return to work and social participation.

### **Disability**

For many disabled people, rehabilitation in the home environment enables therapy to be tailored directly to real-world functional challenges, such as navigating stairs, accessing bathrooms, or using kitchen equipment. This contextualised approach can improve practical independence. Home-based rehabilitation may also reduce the physical and psychological burden of travel to inpatient facilities, particularly for those with mobility impairments, chronic pain, or fatigue-related conditions.

Additionally, individuals with certain neurodiverse conditions or cognitive impairments may benefit from the predictability and reduced sensory stimulation of their home environment compared to busy inpatient wards.

### **Sex**

Women, who are statistically more likely to undertake unpaid caring responsibilities, may benefit from reduced need to travel or stay away from dependents. Home-based rehabilitation can make it easier to balance recovery with family responsibilities. For men, community-based models may support earlier reintegration into family and social roles, which can positively influence motivation and engagement in recovery.

### **Race (Ethnicity)**

For individuals from minority ethnic communities, home-based rehabilitation may:

- Reduce institutional barriers or mistrust associated with hospital settings
- Allow family involvement in culturally appropriate ways
- Enable care delivery that is more responsive to cultural norms within the home context

With appropriate interpretation support, home-based care can provide a more personalised and culturally sensitive rehabilitation experience.

### **Religion or Belief**

Home-based rehabilitation can offer increased flexibility around religious observance, prayer times, and dietary practices. Delivering care in the home may allow individuals to maintain religious routines and modesty requirements more comfortably than inpatient settings. This may improve engagement and satisfaction with care.

### **Pregnancy and Maternity**

Home-based rehabilitation can be particularly beneficial for pregnant or postnatal individuals, as it:

- Reduces the need to travel with infants
- Supports recovery while maintaining caregiving responsibilities
- Enables therapy to be integrated into daily parenting activities

This model may reduce stress and improve adherence to rehabilitation programmes during a period of significant physical and emotional adjustment.

### **Gender Reassignment**

For some transgender individuals, avoiding prolonged inpatient stays may reduce exposure to environments where they may feel vulnerable to discrimination or misgendering. Home-based services, when delivered by trained and inclusive staff, can offer a greater sense of privacy, dignity and control over personal information.

### **Sexual Orientation**

Older LGBTQ+ individuals are statistically more likely to live alone and may value rehabilitation that enables them to maintain independence within their chosen home environment. Home-based rehabilitation can reduce reliance on institutional settings and may enhance feelings of safety and autonomy, particularly when services clearly demonstrate inclusive practice.

### **Marriage and Civil Partnership**

For individuals who are married or in civil partnerships, home-based rehabilitation enables partners to be actively involved in the recovery process. This can:

- Improve continuity of care
- Increase confidence in managing rehabilitation tasks
- Strengthen informal support networks

For individuals who are widowed or single, home-based rehabilitation may help preserve independence and delay or prevent admission to long-term care settings.

### **Wider Equality Benefits**

Across multiple protected characteristics, home-based rehabilitation may:

- Promote independence and self-management
- Reduce travel barriers and associated costs
- Enhance patient choice and control
- Support culturally competent and personalised care
- Facilitate integration with community services
- Reduce disruption to family, employment and social roles

When supported by appropriate clinical stratification, reasonable adjustments, and robust monitoring of outcomes across equality groups, home-based rehabilitation has the potential not only to avoid worsening inequalities but to actively reduce them by increasing accessibility, flexibility and person-centred care.

**Negative Impact**

|                              |  |   |  |  |
|------------------------------|--|---|--|--|
| <input type="checkbox"/> Sex | <input type="checkbox"/> Race                  | <input type="checkbox"/> Disability                     | <input type="checkbox"/> Religion & Belief   | <input type="checkbox"/> Sexual Orientation  |
| <input type="checkbox"/> Age | <input type="checkbox"/> Pregnancy & Maternity | <input type="checkbox"/> Marriage and Civil Partnership | <input type="checkbox"/> Gender Reassignment | <input type="checkbox"/> Armed Forces<br><input type="checkbox"/> Other health inequality (please state below) |

Provide a narrative about the negative impact for any of the protected characteristic groups plus health inequality groups (such as digital exclusion). Also include intersectional impact where possible here:

**1. Age  
Potential Impact**

Older people may experience barriers to engaging with home-based rehabilitation due to:

- Digital exclusion or low confidence with technology where this is used by visiting teams
- Frailty, cognitive impairment or sensory impairment
- Greater need for supervision or therapy intensity

Younger working-age adults may experience challenges attending scheduled sessions due to employment or caring responsibilities.

**Evidence**

Rehabilitation research indicates that therapy intensity and structured supervision influence outcomes in frail and older populations.

**Mitigation**

- Provide non-digital and hybrid service models
- Use frailty and complexity stratification to determine appropriate therapy setting
- Monitor access, uptake and outcomes by age group

**2. Disability  
Potential Impact**

Individuals with physical, sensory, cognitive or learning disabilities may:

- Require specialist equipment not easily available in the home
- Need structured environments more readily available in inpatient settings
- Face challenges with self-directed exercise programmes
- Require reasonable adjustments to engage effectively

**Evidence**

NICE rehabilitation guidance emphasises equitable access and reasonable adjustments for disabled people. Research on stroke and complex rehabilitation demonstrates that people with severe disability may require higher therapy intensity and structured support to achieve optimal outcomes.

**Mitigation**

- Conduct individual reasonable adjustment assessments
- Provide equipment loan schemes and assistive technology
- Ensure pathway flexibility (home-based rehabilitation should not be the default where clinically inappropriate)
- Provide carer education and structured support packages
- Monitor outcomes by disability type and severity

**3. Sex****Potential Impact**

Women are also more likely to live alone in later life. Men may be less likely to engage proactively with community-based services.

**Evidence**

Research literature indicates gender differences in help-seeking behaviours and service engagement.

**Mitigation**

- Offer flexible scheduling
- Monitor uptake and outcomes by sex
- Provide targeted engagement approaches where disparities are identified

**4. Race (Ethnicity)****Potential Impact**

People from ethnic minority communities may experience:

- Language barriers
- Lower awareness of available services
- Cultural perceptions that influence engagement

**Evidence**

The NHS Race and Health Observatory highlights persistent ethnic inequalities in healthcare access and outcomes. National data shows variation in post-acute service uptake by ethnicity.

**Mitigation**

- Provide interpretation and translation services
- Develop culturally appropriate materials
- Monitor referral, uptake and outcomes by ethnicity
- Engage community organisations in service design and evaluation

## **5. Religion or Belief**

### **Potential Impact**

Home visits may conflict with religious observance or prayer times. Some individuals may prefer same-sex clinicians due to religious beliefs. Cultural expectations may influence acceptance of home-based care.

### **Evidence**

NHS equality guidance recognises the importance of culturally competent care in reducing inequalities and improving patient experience.

### **Mitigation**

- Provide flexible scheduling around religious observance
- Respect patient preferences where feasible
- Deliver staff training in cultural competence

## **6. Pregnancy and Maternity**

### **Potential Impact**

Home-based rehabilitation may increase accessibility for pregnant or postnatal individuals. However:

- Postnatal mental health issues may affect participation
- Fatigue or physical recovery needs may require tailored input

### **Evidence**

Postnatal rehabilitation evidence suggests home support can improve access but requires flexible and coordinated care to ensure adherence and safety.

### **Mitigation**

- Offer child-friendly scheduling
- Screen for perinatal mental health concerns
- Coordinate care with maternity and health visiting services

## **7. Gender Reassignment**

### **Potential Impact**

Trans individuals may:

- Have concerns about confidentiality during home visits
- Experience anxiety about discrimination or misunderstanding
- Prefer clarity around staff identity and inclusivity

### **Evidence**

Stonewall reports ongoing healthcare discrimination experienced by trans individuals. NHS equality standards emphasise inclusive practice and dignity.

### **Mitigation**

- Provide staff training in inclusive practice

- Respect chosen names and pronouns
- Ensure confidentiality is clearly communicated
- Allow patient preferences regarding visiting staff where feasible

## 8. Sexual Orientation

### Potential Impact

LGBTQ+ individuals may:

- Be more likely to live alone in older age
- Have reduced informal carer support
- Feel hesitant to disclose personal circumstances in home settings

### Evidence

Stonewall research identifies disparities in healthcare confidence and social support among LGBTQ+ populations.

### Mitigation

- Avoid assumptions about household composition
- Use inclusive assessment documentation
- Provide explicit reassurance regarding non-discrimination

## 9. Marriage and Civil Partnership

### Potential Impact

Individuals who are single, widowed or divorced may:

- Have limited informal support
- Experience greater isolation
- Require additional practical assistance

Spousal carers may experience increased burden when rehabilitation shifts to the home environment.

### Evidence

Research demonstrates that social isolation is associated with poorer rehabilitation engagement and outcomes.

### Mitigation

- Screen for social isolation
- Provide enhanced support where required
- Offer carer assessments and support
- Signpost to voluntary and community services

ments here

(you can share further details and mitigations below in 2.2)

**No Effect**

Your policy might not have a positive or negative impact, or it might maintain a status quo – complete this section if ‘not applicable’

The above analysis is on the broader impact of moving to more home based rehabilitation. The specific proposal around not going ahead with plans to build a rehabilitation unit at Frenchay maintains the status quo, and therefore has no direct impact.

[Add comments here](#)

**2.2 Outline any negative impacts of the proposal on people based on their protected characteristic or other relevant characteristic. Consider how you might level the ‘playing field’ for all people**

| Protected Characteristic(s) | Details of negative impact (e.g. access to service, health outcome, experience, workforce exclusion) | Identify any mitigations that would help to reduce or eliminate the negative impact |
|-----------------------------|--|---|
| Covered above               |  |   |
|                             |  |   |
|                             |  |   |
|                             |  |   |
|                             |  |   |

**2.3 Outline any benefits of the proposal for people based on their protected or other relevant characteristics?**

Outline any potential benefits of the proposal and how they can be maximised. Identify how the proposal will support our Public Sector Equality Duty to:

|   |                                    |
|---|------------------------------------|
| To eliminating discrimination, harassment and victimisation.<br>Covered above | Positive <input type="checkbox"/>  |
|   | Negative <input type="checkbox"/>  |
|   | No effect <input type="checkbox"/> |
| Please describe:<br><a href="#">Add comments here</a>                         |                                    |

|  |           |                          |
|--|-----------|--------------------------|
| To advance equality of opportunity between people who share a protected characteristic and those who don't | Positive  | <input type="checkbox"/> |
|  | Negative  | <input type="checkbox"/> |
|  | No effect | <input type="checkbox"/> |
| Please describe:<br>Add comments here  |           |                          |

|  |           |                          |
|--|-----------|--------------------------|
| To foster good relations between people who share a protected characteristic and those who don't (e.g. does the project raise any issues for community cohesion, or linked to current topics that are contentious in society; will it affect relationships between any groups) | Positive  | <input type="checkbox"/> |
|  | Negative  | <input type="checkbox"/> |
|  | No effect | <input type="checkbox"/> |
| Please describe:<br>Add comments here  |           |                          |

### Step 3: Action Plan

#### 3.1 What actions will you take to mitigate the negative impact outlined above?

| Action  | Timeframe                 | Success Measure                         | Lead         |
|---|---------------------------|---|--------------|
| Ensure that the actions described above are added to service specifications for the commissioning of home based rehabilitation services         | As contracts are procured | Inclusion in service specifications     | ICB          |
| Pass the action plan details to current provider of home based rehabilitation services (Sirona) to ensure that the actions are being undertaken | 2026 Q1                   | Request update from Sirona at end of Q1 | ICB / Sirona |
|   |                           |   |              |
|   |                           |   |              |
|   |                           |   |              |
|   |                           |   |              |
|   |                           |   |              |

### 3.2 How and when will you review the action plan (include specific dates)?

Ensure that the plan is passed to the ICB commissioning team, and filed appropriately to ensure that the actions are included in the development of future commissioning plans.

## Step 4: Impact

### 4.1 What are the main conclusions of this Equality & Health Inequality Impact Assessment?

Share a brief summary of the positive impact the project will make and any negative impact and mitigations, e.g. what steps you have been taken to improve accessibility, and what recommendations you are making to the decision maker.

Explain how the EHIA has informed, influenced or changed the proposal and include a recommendation for the decision maker

#### Summary of Positive and Negative Impacts

##### Positive Impact

The transition from bedded rehabilitation to home-based rehabilitation is expected to deliver several positive equality impacts. Delivering rehabilitation in a person's usual place of residence can improve accessibility by removing the need for travel, particularly benefiting older people, disabled individuals, pregnant or postnatal women, and those with mobility limitations.

Home-based rehabilitation supports independence and functional recovery within a real-life environment, which may improve long-term outcomes and confidence. It also increases flexibility for working-age adults and carers by allowing therapy to be scheduled around employment and caring responsibilities.

The model may enhance dignity, privacy and cultural comfort for individuals whose religion, gender identity, or personal circumstances make inpatient settings less suitable. It also enables greater involvement of family members and informal carers in the rehabilitation process, where appropriate.

Overall, when appropriately designed and monitored, home-based rehabilitation has the potential to increase patient choice, improve experience, and reduce certain barriers to access.

##### Potential Negative Impact

Potential adverse impacts may arise if the service model is not implemented inclusively.

There is a risk of digital exclusion affecting older adults, people on low incomes, or those with limited digital literacy if remote or virtual components are relied upon.

Individuals with complex needs or severe disability may require more intensive or specialist input than can safely be delivered at home, potentially affecting outcomes if not carefully assessed.

There is a risk of increased burden on informal carers if adequate support is not provided. Inequalities in uptake may occur among certain ethnic groups, socially isolated individuals, or those with limited health literacy. People living alone or in unsuitable housing environments may face additional challenges.

Without appropriate safeguards, these factors could widen existing health inequalities.

**Mitigations**

- Maintain a clinically led eligibility and stratification process to ensure home-based rehabilitation is appropriate and safe for each individual.
- Provide reasonable adjustments, interpretation services, and culturally competent care.
- Assess carer capacity and provide appropriate support and signposting.
- Monitor referral, uptake, completion and outcome data by protected characteristic to identify and address disparities.
- Engage service users from diverse communities in ongoing service development and review.

Through proactive monitoring, targeted support, and a commitment to proportionate universalism, moving to home based care can reduce barriers to care while avoiding the unintended widening of health inequalities.

| <b>Select a recommended course of action:</b>  |                          |
|--|--------------------------|
| <b>Outcome 1:</b> Proceed – no potential for unlawful discrimination or adverse impact or breach of human rights articles has been identified. E.g. proposal is not likely to have any detrimental impact on any group   | <input type="checkbox"/> |
| <b>Outcome 2:</b> Proceed with adjustments to remove barriers identified for discrimination, advancement of equality of opportunity and fostering good relations or breach of human rights articles. E.g. arrangements put in place to produce a BSL video to promote changes to a service   | <input type="checkbox"/> |
| <b>Outcome 3:</b> Continue despite having identified some potential for adverse impact or missed opportunity to advance equality and human rights (justification to be clearly set out). E.g. pilot benefits one neighbourhood due to funding restrictions   | <input type="checkbox"/> |
| <b>Outcome 4:</b> Stop and rethink as actual or potential unlawful discrimination or breach of human rights articles has been identified. E.g. dress code policy discriminates against people who practice particular religions; new service that proposes to detain patient but insufficient evidence of safeguarding or human rights considerations in place | <input type="checkbox"/> |

**Step 5: Review**

All Equality & Health Inequality Impact Assessments should be reviewed internally and obtain sign off to show an organisational commitment.

**Reviewer’s Feedback (this document should be reviewed by an equality officer or trained project lead/senior manager)**

Add comments here

|   |
|---|
|   |
| <b>Equality Officer Name:</b>                 |
| <b>Equality and Inclusion Team Signature:</b> |
| Date:   |

## Equality Delivery System 2022

Equality, Diversity & Inclusion is an evidence-based practice, Healthier Together partners are committed to demonstrating how we have taken steps to improve patient and service user access, experience and outcomes and how we have created an inclusive working environment for our staff, including supporting our workforce to have healthy and fulfilled lives. Please indicate which Domain your project will deliver against:

### Domain 1 – Commissioned & Provided services

- 1A: People can readily access the service.
- 1B: Individual people's health needs are met
- 1C: When people use the service, they are free from harm.
- 1D: People report positive experiences of the service.

### Domain 2 – Workforce health and wellbeing

- 2A: When at work, staff are provided with support to promote healthy lifestyles and manage their long term conditions
- 2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source.
- 2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source (response to Covid-19)
- 2D: Staff recommend the organisation as a place to work

### Domain 3 – Inclusive Leadership

- 3A: Board members and senior leaders (Band 9 and VSM) routinely demonstrate their commitment to equality.
- 3B: Board/Committee papers (including minutes) identify equality related impacts and risks and how they will be mitigated and managed
- 3C: Board members, system and senior leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients

Add comments here