Agenda Item 8

Report to Policy Committee

Author/Lead Officer of Report: Alexis Chappell. Director of Adult Health and Social Care

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Report of:	Director of Adult Health and Social Care, Deputy Place Director Sheffield Place - Integrated Care Board,
Report to:	Adult Health and Social Care Policy Committee
Date of Decision:	8th February 2023
Subject:	Hospital Discharge and Urgent Care Delivery Plan

Has an Equality Impact Assessment (EIA) been undertaken?	Yes		No	
If YES, what EIA reference number has it been given? *(Insert reference number)*				
Has appropriate consultation taken place?	Yes	x	No	
Has a Climate Impact Assessment (CIA) been undertaken?	Yes		No	
Does the report contain confidential or exempt information?	Yes		No	x

If YES, give details as to whether the exemption applies to the full report / part of the report and/or appendices and complete below:-

*"The (**report/appendix**) is not for publication because it contains exempt information under Paragraph (**insert relevant paragraph number**) of Schedule 12A of the Local Government Act 1972 (as amended)."*

Purpose of Report:

The overarching Adult Health and Social Care vision is for every adult in Sheffield to be able to age well and live the life they want to live, with choice and control over the decisions that affect them.

The purpose of this report is to articulate the ambition in relation to hospital discharge, urgent care, and avoidable admission as well as a delivery plan so that individuals can return home from hospital when well.

Recommendations:

It is recommended that the Adult Health and Social Care Policy Committee:

- Agrees the direction of travel and planned improvement activity
- Requests that the Director of Adult Health & Social Care provides the Committee with updates on progress against the Delivery Plan on a 6 monthly basis.

Background Papers:

None

Lead Officer to complete:-		
1	I have consulted the relevant departments in respect of any relevant implications indicated on the Statutory and Council Policy Checklist, and comments have been incorporated / additional forms completed / EIA completed, where required.	Finance:
		Legal: Patrick Chisholm
		Equalities & Consultation: Ed Sexton
		Climate: Jessica Rick
	Legal, financial/commercial and equalities implications must be included within the report and the name of the officer consulted must be included above.	
2	**SLB member who approved submission:**	*Alexis Chappell*
3	**Committee Chair consulted:**	*Councillors George Lindars Hammond and Angela Argenzio*
4	I confirm that all necessary approval has been obtained in respect of the implications indicated on the Statutory and Council Policy Checklist and that the report has been approved for submission to the Committee by the SLB member indicated at 2. In addition, any additional forms have been completed and signed off as required at 1.	
	Lead Officer Name: *Rebecca Dixon*	**Job Title:** **Service Manager**
	Date: 15th January 2023	

1. PROPOSAL

1.1 Our collective ambition across health and care services in Sheffield is to prevent admission and readmission to hospital where possible so that individuals can live independently and well at home. Prevention is our preferred and local approach in Sheffield.

1.2 Where individuals do require a period in hospital our collective ambition in line with the introduction of the Health and Care Act 2022 is that we **make discharge personal** where individuals and their families have good experiences during their stay in hospital, experience a positive, safe, and timely discharge and feel involved in planning for discharge.

1.3 Partners across the city agree on and are committed to the principle of 'home first' and optimising on-going care and support through timely out of hospital assessment.

1.4 Delivery Upon Our Ambitions

1.4.1 To evidence delivery of our ambition both towards prevention of admission and towards home-first approach, a joined-up health and care approach to measuring impact is in place through locally agreed metrics agreed through the Better Care Fund (BCF) Update, Annual Report 21/ 22 and BCF Plan for 2022/2023 which was noted at Committee in November 2022.

1.4.2 The BCF indicators along with current position are noted below, with a comparison over last 5 years:

Indicator	BCF Target 2021/ 2022	Position 2021/ 2022	Trend
Proportion of older people still at home 91 days after discharge from hospital into reablement or rehabilitation (effectiveness of reablement).	80%	80.5%	
Older adults whose long-term care needs are met by admission to residential or nursing care per 100,000 population (admissions to residential care homes)	767.6	661	
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (avoidable admissions to hospital for conditions that can typically be managed in a community setting).	1052.3	764.7	
Improving the proportion of people discharged home, based on data on discharge to their usual place of residence (discharge to usual place of residence).	96.6%	97.6%	

1.4.3 The BCF data does highlight that there is a positive move towards the shared principle of home first in Sheffield. This further highlighted by the benchmarking data noted below, which builds upon the Adult Social Care benchmarking data provided to Committee in September 2022.

1.4.4 In summary, benchmarking highlights that Sheffield has

- Increased requests to adult social care from hospital by 20%, as noted in the Adult Social Care Financial Recovery Update to Committee in December 2022.
- Offers double the amount of people enablement opportunities than comparators upon discharge and is equal to comparators (CIPFA, Core Cities, Yorkshire and Humber) in terms of effectiveness of the enablement offer.
- Continues to support more older people in the community than comparators whilst supporting a similar number of people within care homes as to CIPFA groups but less than Core Cities groups. The number supported within care homes reduced nationally during 20/21 due to the COVID pandemic.
- Same rate (15.7%) of emergency admission occurring within 30 days of the last, previous discharge from hospital after admission as comparators.
- Lower than comparators about unplanned hospitalisation for chronic ambulatory care sensitive conditions (avoidable admissions to hospital for conditions that can typically be managed in a community setting).
- Lower than CIPFA and Core City comparators for emergency hospital admissions due to falls in people aged 65 and over per 100,000 aged 65.

1.5 Making Discharge Personal – Adult Social Care Update

1.5.1 To continually improve our delivery of services, a partnership approach has been adopted across Sheffield, reflected through our approach to Adult Health and Social Care Strategy, Delivery Plan Better Care Fund, Tackling Inequalities and Improving Outcomes, the Future Design of Adult Social Care and Supports to Unpaid Carers discussed at Committees in November and December 2022.

1.5.2 Over the past couple of years there has been a focus on continuous improvement, following on from the adult social care self-assessment completed in 2021, which the updates were noted at the Healthier Communities and Adult Social Care Scrutiny Committee held on 16th March 2022 and through the DASS reports to Committee. This has included looking at main risks, challenges and reasons for delay which has been provided to members.

1.5.3 As part of this we have focused on improving outcomes for older adults as well as adults with a learning disability, mental health, and autism as we believe that it is important that all individuals have positive experiences.

Our Support to Older Adults

1.5.4 In line with this, several improvement actions were undertaken during 2022 as a partnership across health and care colleagues to enable older adults to be discharged when well, linked to our joint strategic approaches. These include:

- Care At Night – Reduced waiting lists, leading to no waits and an agility to respond to surges in referrals. Through joint working with health partners the recommissioning of Care at Night support was approved at Committee in December 2022 will achieve a sustainable long-term way forward.

- Care Home Trusted Assessment – Reduced waiting lists, leading to no waits and an agility to respond to surges in referrals made. The service was brought in house following a review of provision in 2022 and partnership arrangements are in place for ongoing learning and review of the service provision.

- Access to Care at Home Support – Reduced waits through implementing new ways of working and a test of change, relating to temporary additional 1600 homecare hours funded through health following approve at finance committee in September 2022. This programme is embedded and is demonstrating that a new model of care management and review is having a positive impact on flow in the system as well as individual outcomes.

- Enablement Interventions – Waits have reduced significantly in 2022, through new ways of working and reconfiguring the service around primary care to lay foundations for more integrated working with health colleagues in communities across Sheffield.

- Temporary Care Home Support – Temporary Care Home Beds were recommissioned following approval by Committee in June 2022. This has introduced clearer pathways and support arrangements to support discharge from hospital.

- Partnership with Voluntary Sector – The voluntary sector are key partners in Sheffield with a focus on enabling individuals to return home from hospital who do not need care and support. Through temporary funding provided via the Better Care Fund funding announced in Autumn, this has been further tested to help ascertain a longer-term model.

1.5.5 In going forward, its aimed to consolidate the learning from this winter as well the future design of adult care in 2023/2024 alongside implementation of the transformation of homecare services, agreed at Committee in June 2022, transformation of care homes, brought for approval at Committee today and development of virtual wards in the community.

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1.5.6 It's aimed that this will support a longer-term approach to embedding outcomes focused and enablement across care at home, which will also support our approach to prevention of admission and making discharge personal as well as delivery upon national guidance.

Our Support to People with a Learning Disability and/ or experiencing Mental Ill Health

1.5.7 Several improvement actions were also undertaken during 2022 as a partnership across health and care colleagues to enable adults with a learning disability and people experiencing mental ill health to be discharged when well, linked to our joint strategic approaches. These include:

- Access to health and care support - Waits have reduced by 40% over the past three months due to joint working across both Sheffield Council and Sheffield Health and Social Care Trust. It's planned to build upon our learning through dedicated learning events and review to enable a joint focused improvement activity throughout 23/24.

- Prevention of Admission and Out of Area Placements – Our priority and focus remains' on prevention of admission and with that our priority is to building on our joint developments relating to Firshill Rise discussed at Health Scrutiny Committee Sub Committee in December 2022 and bespoke joint commissioning developments. A thematic review is underway.

1.5.8 Aligned with our commitment made through the Adult Social Care Strategy and our future design of social care, Adult Social Care also plan to measure and report to Committee the following indicators from October 2023 (to allow for time to develop toolkit for reporting) for Adult's eligible for Adult Social Care:

- Length of Stay: % of people who have a social care need who have a length of stay in hospital longer than 14 days after being assessed as medically fit for discharge.
- Satisfaction: Adults and Carers Satisfaction with the discharge process
- Outcomes: % Adults Discharged Outcomes Met: % expressed outcomes fully or partially met

1.5.9 It is aimed that by moving towards a personalised approach our focus is on demonstrating our impact on individuals' wellbeing outcomes and independence and using learning from individuals' and family members experiences to continually improve our approach to prevention of admission and discharge from hospital.

1.6 Delivery Planning and Priorities for 23/24

1.6.1 A There are several good practice guidance's which promote joined up working across health and care which promote admission avoidance and enabling people to return home from hospital when they well. This is set alongside benchmarking with other authorities, ongoing quality improvement and review against national guidance's which includes.

1.6.2 As a next step, during 23/24 its intended to undertake key projects to continue to improve and build a sustainable system of working which prevents admission and enables safe, timely and personalised discharge from hospital. These projects include:

- Development of a shared approach to recording waits so that a system we have an accurate understanding of waits and this can inform ongoing planning.
- Learning from implementation of the additional homecare hours test of change and from responding to seasonal pressures as to a future model and way of working.
- Learning from new legislation and ensuing statutory guidance, noting that the new Health and Care Act 2022 s91 repealed current legislation and placed new duties in relation to patient and carer involvement in discharge.
- Use of support and improvement events as a way of agreeing a team Sheffield view of what good looks like, the pathways and supports needed to deliver this, how we establish the foundations for sustainable approaches to admission avoidance and discharge and deliver upon both Adult Social Care legal and performance objectives, the ambitions set out by the Better Care Fund noted above as well as the objectives set out for NHS in the NHS Planning Guidance 2023/ 2024.
- A joint health and care delivery plan following on from the outcomes of the improvement events focused on prevention of admission, timely and safe discharge and positive outcomes for individuals and families with clear milestones and trajectories to getting to our what good looks like and making discharge personal.

1.6.2 Oversight of this plan will be undertaken through updates provided to Committee every six months as to progress made and through the following governance arrangements:

- An Urgent and Emergency Care Delivery Board (UEC) chaired by Executive Place Director, Sheffield which involves all strategic leaders across acute, community, primary care, and mental health, care, housing, and voluntary sector in setting the strategic direction for Urgent Care and oversight of performance.
- A Sheffield System Discharge Improvement Group (SSDIG) chaired by the Sheffield ICB Place Team, which brings together all operational partners in the City, to enable timely discharge from all settings and local delivery of national guidance.

- Escalation calls and an operational discharge hub led by Sheffield Teaching Hospitals NHS FT which manages day to day operational discharge flow and risks providing escalation to SSDIG and enabling delivery of key actions
- Internal organisational meetings in which each organisation can assure delivery upon their organisational commitments in relation to discharge.
- South Yorkshire Performance Calls with NHS England.

Health and Care Teams across Sheffield work operationally and tactically to work as one - Team Sheffield team to maximise our ability to support people's discharge journeys together.

1.7 Resourcing Prevention of Admission and Discharge

1.7.1 There have been three national funding streams made available during Winter 2022/23 to the Sheffield system, which end on 31st March 2023.

1.7.2 The ending of and the short-term nature of these funding streams presents a risk, in that without guaranteed funding the schemes described below ends on 31st March 2023, which will subsequently impact on availability of resource to deliver timely discharge and development of sustainable long-term plans for Sheffield. This risk is also set alongside the priority to reduce homecare spend to enable delivery of the local authority budget in balance.

1.7.3 Each of these short-term funds is focused upon facilitating discharge from hospital beds and enabling flow in the discharge pathways within the city and are being managed through the governance of the Better Care Fund with oversight by the Sheffield Partnership Board. These funds are:

- £3,380m was allocated to Sheffield by way of NHS England BAF Funding in September 2022 for use between October 2022 and March 2023. Of that £2.427m was allocated to Adult Social Care to undertake a test of change with additional 1600 homecare hours where the focus is increasing the pace of uptake and hours of home care and the remainder funded intermediate care beds commissioned by Sheffield Teaching Hospital.

- Following that, £5,575m was allocated to Sheffield in November 2022 as a combination of funding to Adult Social Care and NHS ICB via the Better Care Fund for use between November 2022 and March 2023. This funding was used to fund 45 local schemes which are targeted at mitigating discharge risk identified in the system. The final guidance relating to the terms of the on-going money are expected to be released by the end of February 2023.

- Finally, the latest announcement in January 2023 has been funding to purchase step down bedded care for a period of four weeks. This approach to discharge support has not been utilised to date in Sheffield as it creates additional locations to target resources, instead the focus has been on facilitating returning an individual to

their usual residence in the first instance. The funding is also reimbursement of actual costs incurred rather than an allocation of resources.

1.7.4 National funding is not available for admission avoidance, prevention, or step-up care to maintain individuals at home. Sheffield is still committed to this approach being the most beneficial for individuals, as demonstrated by the Team Around the Person outcomes evidenced in recent years and has therefore continued to grow these services with local funding and transformation schemes.

2. HOW DOES THIS DECISION CONTRIBUTE

2.1 The hospital discharge and urgent care delivery plan and proposed approach going forward, is a core element of achieving the ambitions outlined in the Adult Social Strategy and in particular Commitments.

2.2 This proposal directly supports the future design of Adult Social Care (operating model) and, as such, enables removal of avoidable demand and helps to ensure an efficient, effective system. The design of the new system is rooted in improving the experience of people through the care system and maximising their independence wherever possible.

3 HAS THERE BEEN ANY CONSULTATION?

3.1 The purpose of this report is to provide an update in relation to hospital discharge. Consultation is undertaken during the development of direct activity relating to admission and discharge.

3.2 An overall approach to coproduction and involvement is also a key element, ensuring that the voice of citizens is integrated into all major developments ahead following on from the Coproduction strategy approved at Committee on 19th December 2022. It's planned that by embedding an outcome focused approach in relation to discharge and by engaging with our emerging citizens engagement activity, we will ensure voices of individuals are heard and acted upon.

4. RISK ANALYSIS AND IMPLICATIONS OF THE DECISION

4.1 <u>Equality Implications</u>

4.1.1 The Council's legal duties under the Equality Act 2010 include having due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations in respect of people's age, disability status, race or other characteristic protected by the Act.

4.1.2 We use Equality Impact Assessments (EIAs) to assess how our functions as a public authority are contributing towards these duties. The Council also requires that we consider additional characteristics and measures, including people who have unpaid caring responsibilities, poverty & financial inclusion, or geographical impact.

4.1.3 The EIA covering this report is being reviewed and updated to ensure all available equality and demographic information can help to assess whether (or not) there are any additional inequalities.

4.2 Financial and Commercial Implications

4.2.1 There are several funding streams associated with discharge as described above.

4.3 Legal Implications

4.3.1 The core purpose of adult health and social care support is to help people to achieve the outcomes that matter to them in their life. The Care Act 2014 sets the Council's statutory power to direct the provision that:

- promotes wellbeing
- prevents the need for care and support
- protects adults from abuse and neglect (safeguarding)
- promotes health and care integration
- provides information and advice
- promotes diversity and quality.

4.3.2 Beyond the Act itself the obligations on Local Authorities are further set out in the Care Act statutory guidance issued by the government. By virtue of section 78 of the Act, Local Authorities must act within that guidance.

4.3.3 The Care Act Statutory Guidance at paraph 4.52 requires Local Authorities to:

"… have in place published strategies that include plans that show how their legislative duties, corporate plans, analysis of local needs and requirements (integrated with the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy), thorough engagement with people, carers and families, market and supply analysis, market structuring and interventions, resource allocations and procurement and contract management activities translate (now and in future) into appropriate high quality services that deliver identified outcomes for the people in their area and address any identified gaps".

4.3.4 Further, under the Health and Care Act 2022 and the associated guidance Local Authorities are required to work with local health systems to provide local discharge models that best meet the needs of the local population that are affordable within existing budgets available to NHS commissioners and local authorities.

4.4 Climate Implications

4.4.1 There are no direct climate implications associated with approving this report. However, Sheffield City Council – and its 10 Point Plan for Climate Action – is a partner in the Urgent and Emergency Care Board.

4.4.2 We are committed to working with partners aligned with our Net Zero 2030 ambition and where specific procurement/commissioning exercises take place related to care provision we will aim to consider providers approach and performance in terms of managing the climate impacts of the services they provide. This would be done via more detailed CIA's for specific procurements.

4.4.3 Many other partner organisations on the board will also have their own climate strategies. The role of large organisations – who form a big plank of the delivery of this strategy – is important in Sheffield tackling the effects of climate change. The commitments of the 10 Point Plan are also relevant to prevention of admission and making discharge personal.

4.4 Other Implications

4.4.1 There are no other implications

5. ALTERNATIVE OPTIONS CONSIDERED

5.1 **Do nothing**: It would be possible not to produce a plan in relation to discharge – but it would mean any activity would lack focus, coherence, and public accountability.

6. REASONS FOR RECOMMENDATIONS

6.1 As a partnership between agencies in Sheffield, we have made a commitment to admission avoidance.

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