Report to Policy Committee

Author/Lead Officer of Report: Alexis Chappell. Strategic Director Adult Care and Wellbeing.

Report of:	Alexis Chappell, Strategic Director Adult Care and Wellbeing Ian Atkinson, Deputy Place Director Sheffield Place - Integrated Care Board.
Report to:	Adult Health and Social Care Policy Committee
Date of Decision:	14th June 2023
Subject:	Hospital Discharge and Urgent Care Delivery Plan Update and Approval of New Model and Winter Plan

Has an Equality Impact Assessment (EIA) been undertaken?	Yes	x	No	
If YES, what EIA reference number has it been given? 2135				
Has appropriate consultation taken place?	Yes	x	No	
Has a Climate Impact Assessment (CIA) been undertaken?	Yes	x	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*"The (**report/appendix**) is not for publication because it contains exempt information under Paragraph (**insert relevant paragraph number**) of Schedule 12A of the Local Government Act 1972 (as amended)."*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 a new model in relation to hospital discharge 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:

- Approves the Sheffield Place Hospital Discharge Model and Delivery Plan described at Appendix 1.
- Notes current performance in relation to discharge and progress in delivery Making Discharge Personal at Appendix 2.
- Requests that the Strategic Director of Adult Care and Wellbeing provides the Committee with update on progress against the Delivery Plan in March 2024 and to review outcome of learning from phase 1 of implementation on future homecare provision needed to sustain the new model.

Background Papers:

Appendix 1 – Sheffield Hospital Discharge Model
Appendix 2 – Equalities Impact Assessment

<table>
<tr><th colspan="4">Lead Officer to complete:-</th></tr>
<tr><td rowspan="4">1</td><td rowspan="4">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.</td><td colspan="2">Finance: Liz Gough</td></tr>
<tr><td colspan="2">Legal: Patrick Chisholm</td></tr>
<tr><td colspan="2">Equalities & Consultation: Ed Sexton</td></tr>
<tr><td colspan="2">Climate: Alexis Chappell</td></tr>
<tr><td></td><td colspan="3">Legal, financial/commercial and equalities implications must be included within the report and the name of the officer consulted must be included above.</td></tr>
<tr><td>2</td><td>SLB member who approved submission:</td><td colspan="2">Alexis Chappell</td></tr>
<tr><td>3</td><td>Committee Chair consulted:</td><td colspan="2">Councillors Angela Argenzio</td></tr>
<tr><td rowspan="3">4</td><td colspan="3">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.</td></tr>
<tr><td>Lead Officer Name:
Nicola Afzal
Alexis Chappell</td><td colspan="2">Job Title:
Assistant Director Living and Ageing Well
Strategic Director Adult Care and Wellbeing</td></tr>
<tr><td colspan="3">Date: 15th May 2023</td></tr>
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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 Our Sheffield Discharge Model – A New Systems Approach

1.4.1 Following on from the Sheffield Hospital Discharge Improvement Plan approved at Committee in February 2023, significant work has been undertaken as a partnership across Adult Care, Sheffield Teaching Hospitals, Sheffield Health and Care Trust and Sheffield Place Integrated Care Board to understand our performance, demand pressures and agree a model which will enable people to return home from hospital when they are well.

1.4.2 Across Sheffield, we are currently faced with several challenges when trying to discharge people who require additional support. This includes capacity of community services, proactive planning for discharge and process inefficiencies in the system which means that individuals referred to community services are not ready for discharge. These delays and inefficiencies mean people do not have positive experiences of discharge and do not return home from hospital when well.

1.4.3 For most people who have additional support needs following the completion of their acute hospital stay the best place for them to continue receiving the care and support needed is their own home with visits from health and care staff, from family or other community partners or a combination of several elements to meet their needs whilst they recuperate.

1.4.4 Due to this we are committed to implementing the Discharge to Assess model. Discharge To Assess means that people discharged from an acute hospital bed are assessed at home or in another appropriate community setting where assessments about what care they need can take place.

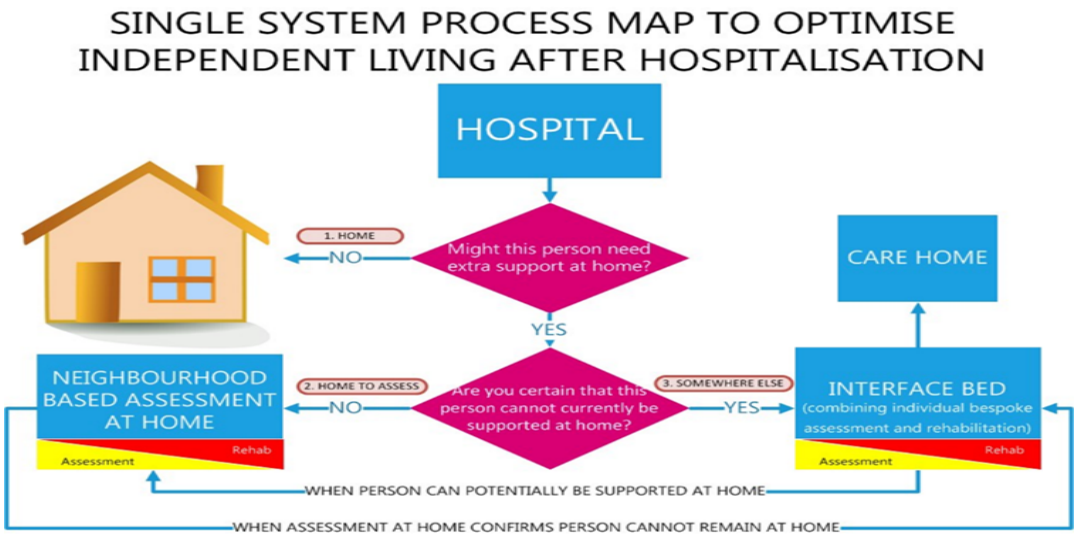
1.4.5 This approach is critical if we are to improve individuals and families experience of discharge, optimise individuals' wellbeing outcomes, maximise our workforce capacity and effectiveness and reduce avoidable demand.

1.4.6 Under the model a minimum of 95% of people over the age of 65 who are admitted to hospital would be able to go home with:

- Pathway 0 – a minimum of 50% able to go home with minimal or no support, led by Sheffield Teaching Hospital,
- Pathway 1 - 45% can go home with support from community service (social care/health), led by Adult Care,
- Pathway 2 – around 4% will need short term rehabilitation in a bedded setting (step down) led as a partnership between Sheffield Teaching Hospital, ICB and Sheffield City Council.
- Pathway 3 - only 1% should require long term residential or nursing care home.

1.4.7 Similar work has been done before within frailty within the Right First Time Programme and demonstrated that it can be done with impressive results and as then, this will require system wide support; recognising that the benefits if we get it right are many and widespread. Previous learning has demonstrated that the importance of eliminating the "queue" cannot be overestimated if we are to realise all the benefits associated with the D2A model.

1.4.8 The model is depicted below and further information including the practical steps, governance, and resourcing to implement the model are described in Appendix 1.



1.4.9 A key element of the new model is about increasing social care community capacity to enable pathway 1 to be realised effectively. To this end, NHS England Capacity Modelling Guidance was used as a reference to inform development of a sustainable position and a two phased approach towards increasing and right sizing community capacity to effectively enable timely discharge.

1.4.10 Phase 1 takes place between September 23 and March 24 and involves implementing:

- Streamlined Homecare and Somewhere to Assess Processes and Systems – Its aimed to move to a model which enables council & commissioned homecare to decide type of care a person needs when they are at home, resulting in care decisions being closer to the person's home.

- Streamlined Somewhere to Assess Ways of Working – Along with a review of residential provision agreed at Committee in February 2023 its planned to look at current S2A ways of working to refine and facilitate discharge. As part of this investment will be provided into additional three social workers funded via BCF to cost of £0.12m for one year to facilitate ongoing timely discharge from somewhere to assess beds.

- Clearing Waits - One off homecare provision to address outstanding waits and enable us to reach a zero-wait position by end October 2023. The cost of the one-off provision based on current waits noted at twice weekly calls (55 waits) and taking into account seasonal increases, would be a one-off cost of £0.08m, funded via BCF, to account for a three day approach to clearing waits.

- Additional Reviewers and Homecare - Additional homecare, review, and leadership provision to maintain a zero-wait position maintaining continuity of provision and make a decisive move towards moving assessment into the community for older adults and people experiencing mental ill health and a learning disability for October to March. The additional provision identified as required during this period is an additional a) 5 assessors and 8 reviewers to form an additional team, (on top of current 8 reviewers funded through 1600hrs project til the end of September), plus management costs at totalling £0.61m (£1.1m annually), b) additional 2,782 homecare hours per week for 9 months at a cost of £2.4m, (£3.1m annually) to account for referral from all Trusts (STH, SHSC, SCT) and modelling in the expected impact of the additional assessment and review capacity. This will be funded by the Joint SCC/ICS Discharge Support Grant via the BCF governance process.

1.4.11 Phase 2 is between April 24 and April 25 and involves:

- Undertaking an evaluation of the impact of the new systems, additional homecare, and key learning and from that determine longer-term homecare provision needed to maintain a Zero Wait position in Sheffield in April 2024.
- Using this learning to inform the funding levels required for home care and the most appropriate option for maintaining the level of homecare required in the long term.
- Seeking approval at Committee for the proposal and implementing

during 24/25 on a sustainable basis.

1.4.12 To enable effective governance arrangements, the following have been put in place as below:

- Joined Up Governance - Strategic governance and scrutiny will be undertaken through the Adult Health and Care Policy Committee and the Health and Care Partnership. Tactical and operational oversight arrangements are in place to enable local collaboration and delivery upon the model.

- Joint Action Plan – A joint action plan to enable implementation of the new model. It's aimed that this will also act as our winter plan to enable timely and effective preparation for winter 2023.

- Joint Monitoring and Management of Risk – our joint governance and oversight of the action plan will enable us to jointly manage the programme and financial risks, particularly if homecare hours required for discharge exceed the 34,000 hours funded by Sheffield City Council per week.

- Joint Up Leadership - A joint leadership post has been established between Sheffield City Council Adult Care & Sheffield Teaching Hospital to build capacity to implement our new model and establish a shared leadership approach to discharge across the City. This post is funded by Sheffield Teaching Hospital.

- Moving Assessment into Community – Redesign of pathways and service delivery in our Care & Wellbeing Services to enable assessment to take place in the Community, streamline pathways and ways of working and establish a homecare provider collaborative of commissioned and council run homecare to utilise our community-based support effectively and efficiently.

1.4.13 Underpinning delivery of the model is effective relationships across health, care, and VCS operationally and strategically which have been built up over time and strengthened in our joint response to COVID. In addition, the use of technology enabled care to maximise opportunities for people to live independently.

1.5 Resourcing Prevention of Admission and Discharge

1.5.1 Following on from the non-recurrent national funding allocated last year, and as reported to February committee, a recurrent grant has been made available to be managed through the Better Care Fund in 2023/25. Again, the aim of the funding is to support the health and social care discharge pathways, with emphasis upon releasing blocked capacity within acute healthcare settings.

1.5.2 At this time there has not been any additional funding allocated by the national teams to support prevention, avoidance of deterioration in conditions and access to statutory services without prior hospitalisation.

1.5.3 The funding, £7.172m in 2023/24 and indicatively £11.787m in 2024/25, has been included in allocations at commissioning organisations to allow longer term planning, support recruitment which enhances capacity, and to add to overall stability while discharge pathways are reviewed, redesigned, and simplified to allow activity flow across the health and social care system.

1.5.4 The schemes implemented with non-recurrent funding during 2022/23 were wide ranging and used as a test of change for all areas where the population could experience a breakage in the discharge process resulting in a delay in returning to their usual place of residence.

1.5.5 The initial planning for 2023/25 builds upon the appraisal of these schemes but is more focused into areas which support the overall longer-term redesign of pathways. This includes identifying funding identified in 1.4.10 of £3.130m for homecare packages and support assessors and reviewers to provide additional capacity and stability to hospital discharges during the implementation of the new contract where existing clients will be transitioning between Providers.

1.5.6 Additional elements to support discharge have also been identified from the Joint SCC/ICS Discharge Support Grant. £0.35m of specialist staff to enable discharge planning, support people with an early diagnosis of dementia or those who require support with medication. £0.64m relating to technological and equipment innovations. In total the planned spend with SCC of the Joint SCC/ICS Discharge Support Grant is £4.1m.

1.5.7 As a partnership of health and care, we remain committed to focusing upon prevention and admissions avoidance within core better fund budgets, and have highlighted the need for investment and national support in this area during a meeting with representatives from the Better Care Fund Support Programme during a recent scoping meeting.

1.6 Making Discharge Personal – Adult Care Performance Update

1.6.1 The Adult Care Policy Committee in February 2023 approved the direction of travel in relation to discharge from hospital. This included greater transparency and accountability in relating to performance reporting and included a move towards Making Discharge Personal.

1.6.2 Making Discharge Personal is an approach taken from Safeguarding where the focus is on individual outcomes and the impact of social care interventions on people. It a way of measuring individuals and their families experience of a positive, safe, and timely discharge and how individuals and families feel involved in planning for discharge.

1.6.3 To this end, Adult Care teams involved in discharge are currently implementing recording systems so that individual's outcomes can be measured from November in line with commitments made in February 2023. This will mean that performance reporting in relation to October will be reported to Committee from December 2023.

1.6.4 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.

1.6.5 In meantime, Adult Care performance in relation to discharge aligned to our Adult Care Strategy Outcomes is as noted below: -

- Hospital referrals remain a significant referrer to Adult Care, with an increase of 20% in last 5 years.
- The proportion of older people who remain at home 91 days after discharge compares well to Yorkshire & Humber and England and it's our ambition by moving assessment into community and moving to a new operating model around primary care that we can prevent re-admission and with that increase % of people who remain at home after discharge.
- The number of referrals to Carers Centre for Carers support have increased by 90% over last couple of years due to a drive to recognise and support unpaid carers upon discharge.
- Homecare provider waits have reduced from 150 at this time last year to 18 in 2023, through a combination of changes to our operating model and a test of change with commissioned providers through the 1600hours project.
- Short Term Enablement and Trusted Assessor waits have reduced, again through a range of changes to how the services operate, following on the report to Committee in February 2023. A focus is on ensuring that no individuals are waiting longer than 7 days to be discharged in preparation for implementation of our new model.
- With the move towards implementing new pathways to support the new model and in particular move assessment to community its aimed that this will reduce impact of homecare hours lost currently.

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 Equality Implications

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 The investment set out in 1.4.10 will be funded by the Joint SCC/ICS Discharge Support Grant (section 1.5.3) via the BCF governance process.

4.2.2 Adult Health and Social Care Policy Committee on 16th June 2022 approved recommissioning of homecare services to a value of 34,000 at 21per hour. The new model takes an enablement approach so it's aimed that the new providers will focus on enabling people to live more independently.

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.

4.5 Other Implications

4.5.1 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 and the development of a new operating model which focuses on building a partnership between primary and social care will aim in longer term to impact on admission avoidance.

6.2 The new discharge model aims to embed an approach where people discharged from an acute hospital bed are assessed at home or in another appropriate community setting where assessments about what care they need can take place. This approach is critical if we are to improve individuals and families experience of discharge, optimise individuals' wellbeing outcomes, maximise our workforce capacity and effectiveness and reduce avoidable demand.

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