Sheffield Health and Care Partnership HCP

www.sheffieldhcp.org.uk

SHEFFIELD HEATH AND CARE PARTNERSHIP

OUR SHEFFIELD PARTNERSHIP APPROACH TO DISCHARGE PATHWAY RE-DESIGN

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The Sheffield Discharge Story

Sheffield currently a **national outlier** with regard to the number of patients within an acute setting defined as having 'no criteria to reside'.

On average **50%** with no criteria to reside require **no** support from community based or care services and can go home with no additional support, **50% require support**.

Due to inefficiency and complicated processes, we **miss opportunities** to get people home in the **optimum** period of being 'medically fit'

Our Health and Care Discharge to Assess services are still in a business continuity mode following a major incident since August 22.

Lots of good work across partners to enable people to return home from hospital, however it only **exacerbates existing model based on assessing people in hospital**.

Some excellent evidence from new discharge schemes and tests for change over winter 23/24 that can support change, such as 1600 hours project.

Financial resource is in the wrong place. 'we are spending money keeping people in the hospital' – **we need to shift resource to the Community so that people can be supported to return home or a homely setting when they are well.**

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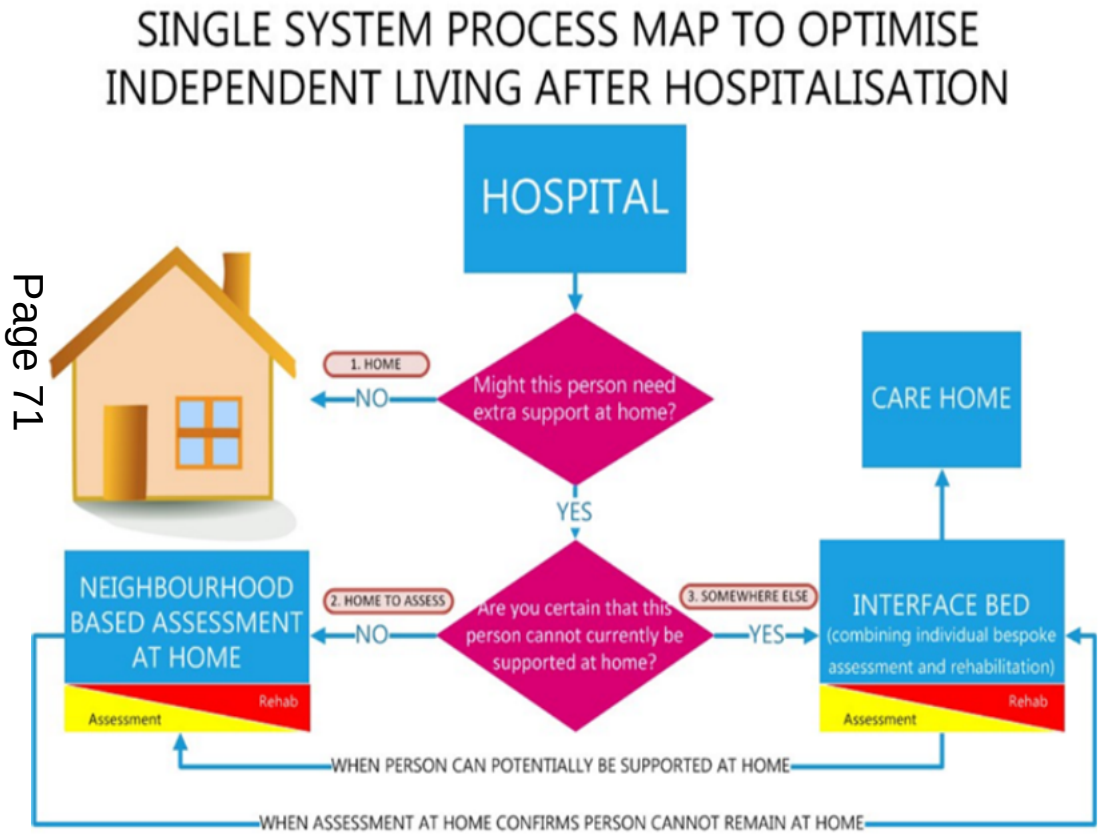
Our Model



We will use the national pathway definitions to describe our work with 95% supported to return home upon discharge.

- Pathway 0 - Likely to be minimum of 50% of people discharged: simple discharge home
- Pathway 1 - Likely to be minimum of 45% of people discharged: able to return home with new, additional or a restarted package of support
- Pathway 2 - Likely to be maximum of 4% of people discharged: recovery, rehabilitation, assessment, care planning or short-term intensive support in a 24-hour bed-based setting, before returning home.
- Pathway 3 - For people who require bed-based 24-hour care: includes people discharged to a care home for the first time (likely to be a maximum of 1% of people discharged) plus existing care home residents returning to their care setting

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How the Model Will Be Supported

Home First

Implement 'Home first' – not a new concept in Sheffield, we have done it before.

Simplify Processes

Improve hospital processes/flow to ensure effective timely discharge, including transport.

Community Focused

Develop a **Community Reception service,** which will PULL patients and co-ordinate community provision to undertake high quality assessment in the most appropriate setting.

Build Homecare Capacity

Establish over capacity in the 'home care sector' to ensure we have enough capacity to support discharge.

Right Support Right Time

Review patients in a timely manner following an initial assessment to enable people to receive right support right time.

Local Ownership

PLACE Partnership board – own the issue and support collective change

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How We Will Implement the New Model

- Implement during **April to November to enable preparation for Winter.**
- Establish **joined up health and care governance** to allow delivery and Operational Decision Making via the Sheffield Urgent and Emergency Care Group. Political scrutiny through Adult Policy Committee.
- **Communicate** - Regular programme and oversight arrangements (Weekly Discharge Programme Delivery Group, Weekly Executive Director Oversight Meeting, Twice Weekly Operational Meetings)
- **Be compassionate as leaders** - staff need time and support to deliver change.
- **Resource Allocation** – Use Better Care Fund discharge allocations in key specialities where we can have the quickest and biggest impact

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Governance for Enabling Discharge Improvement

South Yorkshire Integrated Care Board

Sheffield City Council Adult Health and Care Policy Committee

Sheffield Health and Wellbeing Board

South Yorkshire Urgent Emergency Care Alliance Board

Sheffield Place Partnership Board

Sheffield Urgent and Emergency Care Delivery Group

Weekly Exec Directors Discharge meeting

Twice Weekly Escalation Group (TWEM Operational group)

Discharge Programme Delivery Group