Report to Policy Committee

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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:	31st January 2024
Subject:	Hospital Discharge and Urgent Care Delivery Update

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*"The (**report/appendix**) is not for publication because it contains exempt information under Paragraph (**insert relevant paragraph number**) of Schedule 12A of the Local Government Act 1972 (as amended)."*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 update the committee on the operational progress that has been made in delivering the hospital discharge and avoidable admission paper that was agreed by this Committee on the 14 June 2023.

Recommendations:

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

- Notes the current performance in relation to discharge and progress in delivering phase one of the hospital discharge and urgent care delivery plan.
- Approves the Commissioning Strategy to externally commission a specific Discharge Homecare Contract for a period of 2 years with option to extend for a further period of 1 year.
- Requests that the Strategic Director of Adult Care and Wellbeing provides the Committee with update on progress against the delivery plan in six months.

Background Papers:

Appendix 1 – Sheffield Discharge Programme Update for Committee
Appendix 2 – Adult Care – Hospital Discharge – Implementing the new model
Appendix 3 - EIA

<table>
<tr><td colspan="4">Lead Officer to complete:-</td></tr>
<tr><td rowspan="4">1</td><td colspan="2" 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>Finance:</td></tr>
<tr><td>Legal: Patrick Chisholm</td></tr>
<tr><td>Equalities & Consultation: Ed Sexton</td></tr>
<tr><td>Climate:</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 colspan="2">SLB member who approved submission:</td><td>Alexis Chappell</td></tr>
<tr><td>3</td><td colspan="2">Committee Chair consulted:</td><td>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 colspan="2">Lead Officer Name:
Jo Pass
Kelly Siddons</td><td>Job Title:
Assistant Director Living and Ageing Well
Assistant Director Living and Ageing Well</td></tr>
<tr><td colspan="3">Date: 18th December 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. Our approach is to the principle of 'home first' and optimising on-going care and support through timely out of hospital assessment.

1.3 To enable us to deliver upon our ambitions, as a City-Wide Partnership we have moved towards the national pathway definitions to describe our work with 95% supported to return home upon discharge through a combination of Pathway 0 (50%) and Pathway 1 (45%) whilst the remaining 5% are discharged through Pathway 2 (4%) and Pathway 3 (1%).

1.4 We have established city wide partnership and governance arrangements – set out in out in our Sheffield Discharge Model as approved in the June 23 Health and Social Care Committee, so that we are able to implement reach a position where people are discharged within 24 hours of being identified as having No Criteria to Reside.

1.5 Our partnerships and governance are supported by a joint system leadership post and programme team, which are in process of recruitment, to establish a shared and sustainable infrastructure to deliver on our ambitions and develop an integrated model of delivery which meets the needs of people of Sheffield. It is anticipated that the joint posts will also be able to further strengthen our relationships with VCSE and communities to further enable approaches which support people to remain at home once discharged.

1.6 This report provides an update on delivery against these ambitions and the discharge model agreed at Committee in June 2023. In particular, it focuses on Adult Care Improvement actions, Use of Discharge Funding, Performance and Delivery Upon Discharge Governance and Programme.

1.7 Hospital Discharge Progress Update

1.7.1 Since June 2023, as a partnership we have been implementing Phase 1 of the programme as described in June 2023. Our progress against pathways 0 to 3, including impact on reducing incidence of delays, is set out **in Appendix 1.**

1.7.2 The programme to date has made good progress and is starting to gather pace as the governance and associated management support becomes embedded. We acknowledged when writing our strategy that the 2023 – 24 winter period would be challenging and seen strategically as a 'bridging year' in which we aimed to deliver services while also undertaking transformation. Our collective

improvement journey was always stated as a 2 – 3-year plan and in the first 6 months of June 2023 to December 2023 the health and care system has seen increases in operational pressure as well as sustained periods of industrial action within the NHS.

1.7.3 Our performance position as at the end of December comparative to the same period in the previous year was relatively positive. During this period, we saw increasing levels of Type 1 ambulance arrivals, increased admissions and a subsequent increase in discharges, comparative to the previous year. Despite the increase and operational pressure, our no criteria to reside figures were an improvement on the same time in the previous year and of similar position to other large complex Health and Social Care system across Yorkshire and Humber.

1.7.4 Sheffield continues to discharge the **majority of people (95%) home**, which is in line with our ambitions **of HomeFirst. T**he challenges faced remain our ability to achieve discharge home in a timely manner following agreement that the person has no criteria to residence. Our collective ambition is to continue to meet our local ambitions set out in June 23 and to evidence that we are working to meet national guidance.

1.7.5 Over the past 6 months we have continued to strengthen and build the foundations for delivery upon our local ambitions in 2024. The recent development of an integrated criteria agreement has supported us to establish system-wide principles creating a single narrative across the system with a focus on home as a default. Each element of Pathway 1 and the remit within which it operates provides clarity for the person at the point of discharge and has allowed us to streamline and improve both internal and system processes resulting in reduced numbers of people waiting. This consistent approach enables us to determine how we best enable people to receive the right care at the right time.

1.7.6 Appendix 2 sets out detailed progress in relation to Pathway 1 to 3 with key priorities for 2024. It updates that we have delivered: -

- ✓ **Pathway 1 (Independent Sector Home Care)** - 48% people being discharged home within 48 hours of referral through our independent homecare service. Home Care provider waits have reduced from 151 in December 22 at this time last year to 18 in 2023. This has been supported by the additional home care hours funded by Better Care Fund described to Committee in June, remodelling, and building capacity of our brokerage service as well as engagement with our providers.

- ✓ **Pathway 1 (Council's Short Term Intervention Team)** - Since June 2023 the Short-Term Intervention Team have supported 2569 people to be discharged and reduced waits to 51 people needing support on a weekly basis. The new electronic system will be in place from January 2024 and enable further reporting, efficiencies in our ways of working and achieve delivery of our ambitions.

- ✓ **Pathway 1 (Additional Reviewers**) - Additional reviewers were identified as required to enable and build capacity for discharge. Funding was identified through the Better Care Fund for these posts as noted in June Committee report (additional 8 reviewers to form an additional team, plus management costs at totalling £0.61m (£1.1m annually). This is in addition to the team recruited last year where the value of this team was demonstrated through the winter pressures test for change "1600 hours project" 90% of the new posts have been recruited to and it's planned to complete full recruitment by March 2024.

- ✓ **Pathway 2 (Somewhere to Assess)** –273 people have been discharged to short term residential support settings from the 1st of June until the 31st of December 23. We have reduced social care delays due to people awaiting somewhere to assess beds by utilising additional staff resource to ensure people are assessed and discharged from this pathway in a timely manner. NHS ICB have provided additional funding to enable people who may require health funding to be assessed promptly.

1.7.7 As a city we have also prioritised discharge of people experiencing mental ill health to ensure equity of approach. A dedicated programme is in place with operational leadership from across both Adult Care and Wellbeing and Sheffield Health and Care Trust. Over the past six months this has seen improvements in pathways between our organisations and with that a reduction in people waiting to go home.

1.7.8 In line with our local ambitions towards Making Discharge Personal our teams are currently implementing recording systems so that individual's outcomes can be measured. It's aimed for roll out from 2024 aligned to our new electronic recording systems development. 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. This also aligns with our learning from feedback and complaints noted at Committee today.

1.7.9 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.

1.8 Discharge Homecare Contract

1.8.1 The provision of Home Care is critical to support effective hospital discharge. Improvements have been made over the last year in our pathways and the timeliness of package pick up, but we are keen to do more to deliver outstanding services and support for citizens of Sheffield.

1.8.2 The extension of current contracts to July 2024, agreed at Committee in September 2023, enabled delivery of the additional home care hours and a test of the independent sector pathways to provide support in line with our discharge

model ambitions and the ability to provide a 7-day service therefore increasing responsivity and support for people to be discharged from hospital.

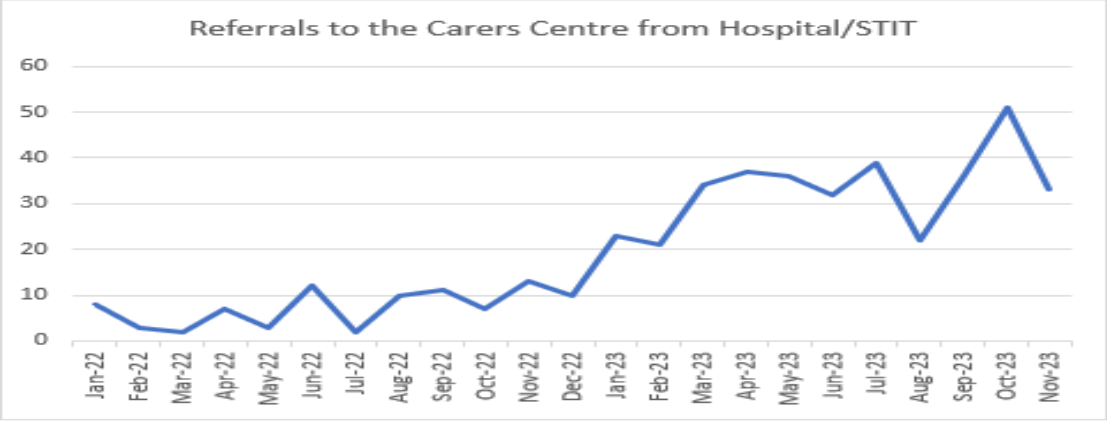
1.8.3 The flexibility to respond to discharge through dedicated home care provision has been a key element in enabling timely discharge and our trajectory to home-first. Current contracts end in July 2024, planned alongside the mobilisation of the new Care and Wellbeing contract, which goes live on 8th April 2024. To ensure stability and sufficiency of the Home Care market through this period, and to support the developing Hospital Discharge and Urgent Care Programme, it is proposed to commission a dedicated home care discharge contract to cover a two-year period with opportunity of extension for a further year.

1.8.4 The alternative is to not have a discharge contract and rely entirely on the new care and wellbeing contract. However, this risks destabilising our new contract during mobilisation and our delivery of discharge including additional reliance on direct awards.

1.9 Unpaid Carers

1.9.1 A priority aligned to our strategic ambitions is to support unpaid carers as set out in our Carers Delivery Plan agreed at Committee in December 2022, our priority has also been to increase the number of unpaid carers being identified and able to access support.

1.9.2 The number of referrals to Carers Centre for Carers support have continued to increase from hospital services as set out below:



1.9.3 A post, specifically focused on carer identification/support has been recruited to in the Short-Term interventions Team (STIT); this focus on carers has contributed to the increased number of referrals illustrated above.

1.9.4 It is essential that we identify carers as early as possible and have good connectivity between health/social care so that we can recognise, value and support our unpaid carers. NHS England's Commitment to Carers (2014) states that 'It takes carers an average of two years to acknowledge their role as a carer. It can be difficult for carers to see their caring role as separate from the relationship they have with the person for whom they care whether that relationship is as a parent, a son or daughter, or a friend.

1.9.5 It is therefore vital that there is good information available to carers in the health system (including point of discharge), so to that end, the Carers Centre has:

- Worked with Sheffield Teaching Hospitals (STH) to produce an animation and guide for people caring for someone who is leaving hospital. This can be found here.
- Worked with STH to revise the 'Do you look after someone?' leaflet which is being trialled in the discharge pack in 'Geriatric and Stroke medicine' (dementia pathway).
- Worked with STH/Sheffield Young Carers to create a 'Carers passport' that aims to identify/support carers who are visiting at STH.

1.9.6 These new resources plus continued multiagency working with Sheffield Teaching Hospitals and the Sheffield Carers Centre will mean that more carers are linked from point of discharge to the Carers Centre so they can get the personalised support they need.

1.10 Resourcing Prevention of Admission and Discharge

1.10.1 Following on from the non-recurrent national funding allocated last year, and as reported to February and June Committee, a recurrent grant has been made available to be managed through the Better Care Fund in 2023/25.

1.10.2 At this time there remains no additional funding allocated by the national teams to support prevention, avoidance of deterioration in conditions and access to statutory services without prior hospitalisation.

1.10.3 As reported in June, 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 enable people to return home when well.

1.10.4 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.

1.10.5 Usage of the Better Care Fund will be provided to March 24 Committee as part of transparency reporting on Better Care Fund.

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 (Appendix 3) 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 Discharge from hospital is funded by the Joint SCC/ICS Discharge Support Grant (see section 1.10) via the Better Care Fund 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. It is not intended that the specific Discharge Homecare Contract will increase the overall number of funded hours/cost. It is now proposed that discharge homecare requirements will go through the new contract instead of through the new Care and Wellbeing contract.

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 is a partner in the Urgent and Emergency Care Board and will promote our Climate Statement, subject to approval with partners.

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.

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.

5.2 In relation to the commissioning strategy for discharge homecare, as set out above, the alternative would be to use the existing homecare contracts but it is felt that this could be destabilising and a specific contract is a better option.

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.