Adult Care –
Hospital Discharge
Implementing the new model

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The New Model

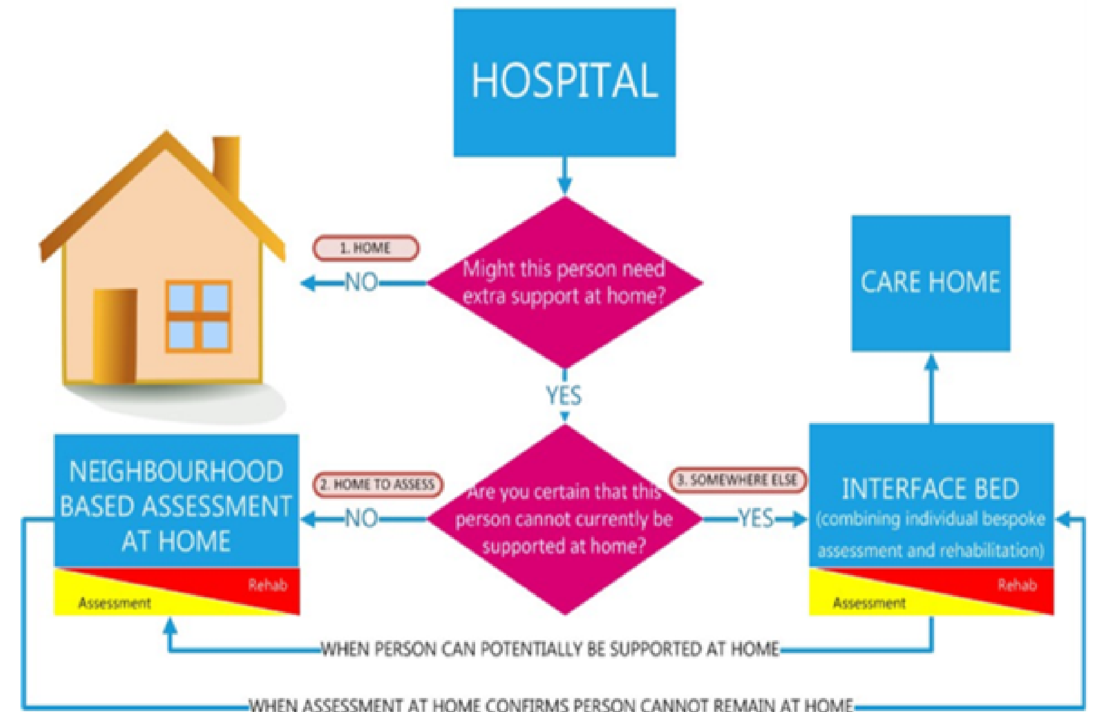
The national pathway definitions describe our work with 95% of people to be supported to return home upon discharge.

They also set out targets to be achieved with regards to % of people on each pathway

- ✓ Pathway 0 - 50% of people discharged: simple discharge home
- ✓ Pathway 1 - 45% of people discharged: able to return home with new, additional or a restarted package of support
- ✓ Pathway 2 - 4% of people discharged for further assessment, care planning or short-term intensive in a 24-hour bed-based setting, before returning home.
- ✓ Pathway 3 - 1% of people discharged who require bed-based 24-hour care to meet long term care and support needs.

"Why not home, why not today?" asked every day, for every patient

SINGLE SYSTEM PROCESS MAP TO OPTIMISE INDEPENDENT LIVING AFTER HOSPITALISATION



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Why Not Home? Why Not Today

We recognise the importance of working collaboratively across our leadership and operational teams to improve outcomes for the individuals and unpaid carers.

- ✓ The new model provides a shared understanding
- ✓ Gives opportunity to change behaviours and process
- ✓ Improves decision Making and timeliness
- ✓ Create strong leadership at a system level

All of which enables us to support the person to return home within 24 hours of No longer having a right to reside

- Our Local Ambition

The Sheffield Discharge Story – So Far

Over the past two years, we have already made significant progress through reducing waits for homecare (from 71 people in 2021 to 36 people in 2023)

Excellent evidence from the winter 22/23 test for change “1600 hours project” that delivered independent sector homecare support within 48 hours of no right to reside and demonstrated the value of post discharge reviews.

NHS England weekly reported performance data highlights that Sheffield discharge more people home than regional and peer comparators and in addition have reduced length of stay over 7 days (from 16% in 2021 to 10.3% in 2023).

Update on our progress against the Discharge model and urgent care model is detailed within this presentation. Phase 1 will be completed in March 24 and the learning will be evaluated to support Phase 2 development.

Work across the system to set out clear discharge pathways to reduce inefficiencies and improve joint working is underway – supporting less hand offs and improved experiences for individuals and carers.

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Hospital Social Work Review Services

About the Service

Hospital Social Work support people leaving hospital with new or increased eligible support needs that can be met by Independent Sector home care, and support unpaid carers. They ensure longer term support decisions at the right time for the person when they are at home and also undertake safeguarding enquiries where a person may be at risk of harm.

What Are We Doing and Our Impact

- ✓ Hospital Social Work has increased capacity in the service by 18 posts over 22/23 and 23/24 and are streamlining processes and documentation.
- ✓ Reassessment of the individuals needs and strength-based support planning now takes place within 4 weeks of discharge in the persons home using the additional reviewers funded by Better Care Fund.
- ✓ 257 post discharge strength-based reviews completed between 1/09/23 and 30/11/23 with 25% of people enabled to live more independently with lower levels of support.

Over priority over the next 6 months is to implement: -

- Personalised information which explains discharge process to individuals and carers.
- Provision of low-level pieces of equipment to promote independence.
- Moving and handling reviews by an Occupational Therapist post discharge.
- Alignment and joint working with Primary Care Networks

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Pathway 1b – Short Term Intervention Team (STIT)

About the Service

STIT are the in house reablement provider, supporting people to return home after a period in hospital, to regain independence. The Service supports on average up to 270 people at any one time and accept referrals seven days a week

What Are We Doing and Our Impact

- ✓ Maximising our Capacity by reducing duplication, streamlining existing processes and to work to the Intermediate Care Framework. Embracing the opportunity to further stabilise, through improving current performance and quality, maximising the use of technology.
- ✓ Since June 2023 Short Term Intervention Team have supported 2569 to be discharged
- ✓ In November 2022 we had an average of 115 people awaiting a service from Short Term Intervention. In December 2023 this was reduced to 51 people waiting set against a weekly referral rate of 80 people.
- ✓ Performing well against the ASCOFF 2b indicator showing 80% of people discharged remain at home 91 days later. This is also against a backdrop of a reduced number of people occupying an acute bed once medically fit for over 7 days and a decreasing number of people readmitted.

Our Priority over next 6 Months are to Implement: -

- ➢ Our new electronic system which goes LIVE in Jan 2024 and move out of business continuity.
- ➢ Use the new system to enable a flexible approach to service planning and delivery
- ➢ Build links with local communities to increase prevention opportunities and connect people to the place that they live by working with people to set clear reablement goals

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Pathway 2 - Somewhere Else to Assess (S2A)

About the Service

S2A is a pathway when people require discharge to a residential or nursing home placement setting for a period of assessment when it is not viable due to health / social care needs to return to the community. Sheffield City Council commission 20 residential beds for people with a residential level of need through the S2A pathway. The ICB commission nursing beds for people with nursing needs.

What Are We Doing and Our Impact

- ✓ An organisational change was completed in November 2023 which has led to integration of S2A in our Care homes Service which has led to increased resilience to support discharge.
- ✓ We have increased capacity by 4 social care practitioner posts, funded by Better Care Fund, to respond to increased demand and complexity of need. This has enabled 273 number of people to be discharged from hospital between June and December 23. Those remaining on the residential pathway for over 28 days has halved in this time period.
- ✓ We have adopted a 'no hand offs' approach. This approach is in line with our practice principles and delivers a better customer experience and continuity of care.

Our Priority the next 6 months is to implement: -

- ➢ Streamlined processes to continue to increase efficiency and reduce hand off's
- ➢ Update the Standard Operating Procedures to ensure it aligns with our vision for hospital discharge.
- ➢ Embed greater utilisation of available data – particularly regarding bed capacity.

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Pathway 1c – Independent Home Care

About the Service

Sheffield City Council contracts with several independent providers of Home Care to ensure that people living at home with longer term support needs have their social care needs and outcomes met. Where people have their social care support arranged by the Council, the Adult Care and Wellbeing Brokerage team facilitate this by securing care from one of our contracted providers. The Brokerage team cover community and hospital referral pathways.

What Are We Doing and Our Impact

- ✓ Reviewed brokerage processes to reduce delays, support system metrics and reporting, and resulting in quicker provider pick-ups. We have also increase capacity by an additional 2 posts.
- ✓ Worked with the Independent Sector and STIT to increase the number of people able to be supported “straight to Independent Sector and with that reducing hand offs experienced by individuals.
- ✓ Awarded new Care & Wellbeing Contract (Home Care). Mobilisation is focused on successful transition, continuity of care and outcomes focused approaches as well as maximising capacity of homecare
- ✓ Between 1st September 23 and 9th January 24, 147 new hospital discharge care support packages were brokered to the Independent Sector. Of these 48% (70) were picked and started with 48 hours.

Our Priority Over the Next 6 Months is to Implement:

- Expansion of support going straight to Independent Sector to reduce hand off’s
- Implementing a Commissioning strategy to support discharge
- Brokerage service development
- Mobilisation of Care & Wellbeing Service

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Mental Health

About the Service

The Mental Health Community Social Work teams work with people in provider placements to support their independence and autonomy and avoid hospital admissions and enable ward discharges to the community. The Approved Mental Health Practitioners (AMHPs) apply the 1983 Mental Health Act legislation to detain people at risk to themselves and others into hospital beds, and the Forensic team support people being discharged from long-stay institutions.

What Are We Doing and Our Impact

- ✓ Introducing a dedicated social work team to work directly with Sheffield Health and Social Care Discharge teams on mental health wards.
- ✓ Developing interim placements with external local providers, supporting people who need a short-term placement whilst their long-term home becomes available, three providers close to finalising arrangements
- ✓ Developing the local market of providers to support people with a range of complex needs. A long-term commissioning initiative which has begun its planning stages.
- ✓ Working with providers through the Provider Forum to support better joint working arrangements. Regular meetings are well attended by all parties and productive.
- ✓ Delays are now significantly reduced with 10 delays at January 2024.

Our Priority Over the Next 6 Months is to Implement:

- ➢ Recruitment plans finalising a permanent social work discharge team for mental health wards
- ➢ Delivery of three interim placements to enable a step down from hospital wards when people are fit for discharge and have long-term placement options.
- ➢ Completion of an 'interfaces' document agreed with the Provider Forum which sets out the duties and responsibilities of statutory and provider organisations in relation to mental health services in Sheffield

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Unpaid Carers

What Do We Offer

A post specifically focused on carer support in the Short-Term Interventions Team (STIT). Carers who are identified by STIT and referred to the Carers Centre can access a wide range of support, from the 'Carer Card' to a Carer's assessment. Further details of the services offered can be found here. Tailored information aimed at carers, 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.
- In 2022 the Carers Centre created a 'Health Liaison Officer' post to improve the connectivity between health and social care so more carers could benefit from the Carers Centre's services.

What is Our Impact?

✓ We have seen an increase in the number of referrals made to carers support

  - ✓ In 2022 there were 88 referrals made
  - ✓ In 2023 there were 374 carers referred to the unpaid carers services

✓ More multiagency working to create better links between health/social care including via the Carers Delivery Plan which has increased focus on discharge support.

✓ New information resources, targeted at carers who are supporting someone to leave hospital.

Our Priority over the next 6 months is to implement: -

➢ Work with the Carers Centre to promote their new information resources for carers i.e. the animation & guide.

➢ Continue to increase carer referrals from STIT to the Carers Centre.

➢ Increase the number of carers referred from STH to the Carers Centre.

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Our Priorities - The Next Steps

Home First

Implement 'Home first' – Maximise Pathway 1 capacity to support more people to return home

Simplify Processes

Improve hospital processes/flow through clear implementation of the action cards, early discharge planning resulting in 24 hour discharges

Community Focused

Develop a **Community Reception service,** which supporting people home undertaking MDT community assessment in the most appropriate setting.

Build Homecare Capacity

Establish over capacity in the 'home care sector' to ensure we have adequate Pathway 1 capacity to meet the timescales within the guidance

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

Continue to develop clear governance for improving discharge and clear accountability

Phase 2 - April 24

supports this phase of development and implementation

Develop further **joined up health and care governance** to enable delivery and operational Decision Making

Work at a system level to implement the guidance to maximise flow through early discharge planning and utilise new project management capacity

Be compassionate as leaders – Work with staff to understand and deliver the change across the system

Resource Allocation – Use Better Care Fund discharge allocations in key specialities where we can have the quickest and biggest impact

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