Report to Policy Committee

Author/Lead Officer of Report:
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Report of:	Strategic Director Adult Care and Wellbeing Deputy Director Place – Sheffield. South Yorkshire and Bassetlaw Integrated Care Board.
Report to:	Adult Health and Social Care Policy Committee
Date of Decision:	19th June 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	

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 31st of January 2024.

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.
- Agrees a 6-month extension to the Somewhere to Assess Temporary Care Home Beds.
- 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 one: Update on Programme Delivery June 2024

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: Laura Foster & Judith Town (10/06/24)
		Legal: Patrick Chisholm
		Equalities & Consultation: Ed Sexton
		Climate: Sarah Farragher
	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* *Strategic Director, Adult Care and Wellbeing Directorate*
3	**Committee Chair consulted:**	*Councillor 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: *Sarah Farragher*	**Job Title:** *System Discharge Lead*
	Date: *4h June 2024*	

1. PROPOSAL

1.1 There is a collective ambition across health and care services to prevent admission and readmission to hospital where possible so that individuals can live independently and well at home. This is our preferred approach. People leaving hospital should be supported to return home, or to their previous place of residence, wherever possible and if necessary be supported with a period of rehabilitation, reablement and recovery before longer term assessment of needs take places. This can be achieved successfully if adult social care, health, housing, and the voluntary sector

work in partnership with the citizens of Sheffield to build resilience within our communities and promote independence.

1.2 The discharge model to support this work was agreed at Committee in June 2023 and an update report Hospital Discharge and Urgent Care Delivery Plan Update was provided in January 2024. This report provides a current progress report on the implementation of this work. A progress report against the system discharge delivery plan can be seen at appendix one.

1.3 This report should be considered in conjunction with the *Adult Care & Wellbeing: Market Sustainability & Commissioning Update* June 2024 Committee Report and associated appendices.

1.4 Recruitment to System Discharge Lead

1.4.1 In line with the Hospital Discharge and Community Support Guidance, a temporary system discharge lead has been appointed as a single coordinator working across the Council and Sheffield Teaching Hospitals NHS Trust (STH) to provide strategic oversight and delivery of hospital discharge. This post is currently hosted by the Council on behalf of the system. This post holder has a dual role that is both accountable to the system and holds the respective organisations to account for ensuring hospital discharge is taking place.

1.4.2 There is now a small project team in place to ensure delivery of the discharge programme.

1.5 Delivery on our Ambitions

1.5.1 The Sheffield system has a commitment to reduce both the number, and the length of time, people remain in hospital when they no longer require acute care.

1.5.2 The improvement trajectory is based on reducing the percentages of beds that are occupied by people who do not need to be in hospital from 17% in February 2024 to 13% by March 2025. In terms of the impact on people this would mean 55 fewer people in hospital beds than there was at the end of February.

1.5.3 Currently the system is making good progress against this target achieving 15% at the end of April and reducing to 14.7% by the middle of May.

1.5.4 The proposal to support this trajectory will be full delivery of the Care Transfer Hub model, review and improvement on all discharge pathways, internal Trust and Council process and consistent and credible data quality and recording.

1.5.5 The current improving picture is because of existing system efforts. The planned improvement activities detailed in this update are not expected to start to impact this position until the end of June.

1.6 Adult Care Delivery and Priorities

1.6.2 The Sheffield system prioritises ensuring people return home, or to their usual place of residence on discharge from hospital. Current performance is at 96% against a national target of 91% and performance over the last twelve months has consistently been above 95%.

1.6.3 Whilst a significant number of these people will return home without ongoing care, or with the same level of care, invariably some people will require new or additional support on immediate discharge from hospital.

1.6.4 The Council are performing well against its targets for delivery of reablement on discharge from hospital (the STIT service) with performance data from April 2024 indicating that 6.4% of people receive reablement on discharge. This against a local Council target of 6% and an England average of 3.3% and has improved against the 2022 baseline of 6.1%.

1.6.5 It is recognised that this is an area of celebration and good practice by our teams. As a key next step and priority, the opportunities to further improve this performance to support people to be discharged when well and extend the offer to:

- People with existing care packages and increased care needs (who currently have care package increases on discharge)
- Provide an enhanced intermediate care service to support people who are placed in short term residential or nursing care beds straight from hospital (discussed further in section 1.10.2)

1.7 One Version of the Truth (the digital discharge tool)

1.7.1 A priority has been to develop a digital discharge tool to deliver a single discharge dataset to support the Care Transfer Hub and inform the system. This includes direct feeds of acute data with an aim of being ready by the middle of June.

1.7.2 There is a revenue cost for this tool of around £12,000 per annum. This is based on the first one hundred users and there is a small increase in costs (c£200) for every additional 100 users. It is anticipated that up to 1,000 users will require access to the tool within the first 12 months. The tool is being delivered from the Discharge Grant, with support from ICB BI existing resource.

1.7.3 Once the initial tool is delivered a plan will be put together for future development that will incorporate local authority data, community data, interfaces with the Trust Electronic Patient Record (EPR) project and wider roll out of the tool. Delivery will be managed through the programme board structure.

1.8

Implementation of the Care Transfer Hub.

1.8.1

The Care Transfer Hub model was recommended in the Delivery Plan for Recovering Urgent and Emergency Care Services in 2023. Phase one of the Sheffield Care Transfer Hub launched on the 20th May 2024. Team members are volunteers from across current social care and health discharge teams. These people are coming together to look at new ways of working to improve hospital discharge.

1.8.2

Unfortunately, a Transfer of Care Hub Manager was not recruited and due to these options within Sheffield Teaching Hospital are being explored to consider how management capacity can be released to support the operational management of this team. There are two new posts (discharge navigators) that will be included in the Care Transfer Hub, these posts have been through grading and will be advertised imminently.

1.8.3

The initial aims of the Care Transfer Hub will be to ensure acceleration of discharge plans for people who need health or social care support (referred to as one pathway one, two and three). This will be achieved by implementing a consistent rhythm of the day approach. This includes attendance at board rounds, developing relationships with the ward and case managing people with complex needs through a multi-disciplinary approach. There will be a standardised approach to recording which in turn will feed the digital discharge tool. Referral process and pathways will be streamlined to reduce delays.

1.8.4

The initial focus will be on people who are discharge ready and will quickly shift a focus to early discharge planning.

1.8.5

Benefits and outcomes from the Care Transfer Hub will be measurable using the digital discharge tool against a baseline for the phase one wards. The most noticeable improvements are expected to be seen in length of time a person remains in hospital once discharge ready. However other expected benefits include increased focus on individual plans and transparency around pathway breakdown and accountability for next actions.

1.8.6

The Care Transfer Hub is expected to contribute significantly to the trajectory ambitions however there is the interdependency to ensure appropriate discharge to assess capacity is in place.

1.9

Pathway one: Describe not prescribe.

1.9.1

Although there is a funding model in place in Sheffield to support statutory assessments taking place outside of hospital (discharge to assess) there is still a significant amount of assessment taking place in hospital. To support the implementation of the Care Transfer Hub a revised approach is being tested to reimplement a full discharge to assess model for people going straight home from hospital with support (pathway one). This will be based

on principles of describing a person's needs rather than prescribing a level of care requirement in hospital.

1.9.2 A set of principles has been established and this will follow the Care Transfer Hub model focusing on the pilot wards. Other systems have seen a reduction of up to 50% in care requirements directly from hospital when using this approach. This was launched on the 22nd May 2024 and will be scaled up once the principle has been established, tested and there is confidence in the approach.

1.9.3 This approach enables delivery upon our assumptions regards future use of the new Care & Wellbeing service set out in the Care and Wellbeing update report in September 2023 and in particular care hours required to meet future demand.

1.10 Pathways two and three: rebalance.

1.10.1 Our ambition is to rebalance bed usage across the system. Only 5% of people over the age of 65% should be going into a bed-based service from hospital. Of those people 4% of people should be supported with active rehabilitation, recovery or reablement whilst in those beds (known as pathway two). Less than 1% of people over the age of 65 should be going into a new residential or nursing placement that is likely to become a long-term arrangement (pathway three).

1.10.2 To rebalance this provision, our priority is to move towards supporting with an enhanced intermediate care team focused on supporting people with complex lives and needs in addition to the transitional therapy approach in the existing pathway two beds. This will dovetail with work that has been undertaken in relation to review of commissioned beds. It is planned to bring these work streams together and agree and approach and delivery plan throughout summer 2024.

1.10.3 The contract for short term temporary beds ends on 30th September 2024. It is proposed to extend the Short-Term Beds Contract by 6 months to enable the review of commissioned beds to be undertaken, a model proposed and retender completed.

1.11 Mental Health

1.11.1 The mental hospital discharge programme has been operating since September 2023. The programme has successfully reduced the number of people who are clinically ready for discharge in our hospital beds through utilisation of the Discharge Grant and improved operational efficiency. We continue to make progress against the trajectory set to in 2023 and have seen significant improvement in delayed discharge since January 2024.

1.11.2 The system has been offered and accepted the opportunity to be involved in a local government association peer review pilot against the community mental health framework whilst not solely focused on discharge the plan will

be to use this learning to support with discharge from mental health inpatient services.

1.12 Unpaid Carers

1.12.1 Identifying carers in hospital is an essential element of joining up health and social care systems including linking carers to prevention focused services in a timely way. Work is ongoing to improve the discharge process for carers and there has been multiagency working via the Carers Delivery Plan to drive the changes needed for carers to feel recognised, valued and supported.

1.12.2 In the last twelve months the Council has supported 450 carers with hospital discharge, against a target of 250 and a 2022 baseline position of 88 carers.

1.12.3 The Sheffield Carers Centre have been working closely with STH to join up process to support hospital discharge including:

- Promotion of discharge resources including an animation and guide via their 'Caring for Someone Coming Out of Hospital' webpage.

- Close partnership working to plan how to embed their discharge resources alongside Sheffield Teaching Hospitals 'Do you look after someone' leaflet.

1.12.4 The Sheffield Carers Centre recently conducted a survey on hospital discharge which received eighty responses. The feedback shows there is still work to be done to improve the discharge process for carers. However, there has also been opportunities to capture a positive experience which the hospital's Patient Experience Team are using this to share with their staff to show what good looks like.

1.12.5 Sheffield Teaching Hospitals have created the webpage 'When someone you support is in hospital' This includes a link to the Sheffield Carers Centre Discharge animation video and guide as well as officially launching the 'Carers Passport' which will help identify more carers.

1.12.6 There is more work to be done but the resources above will encourage carer identification and support at point of discharge, this will help carers live the life they want to live.

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 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.

2.2 In addition, the decision contributes towards the Health and Care Partnership priority towards Hospital Discharge and the Council Plan Priority - People live in caring, engaged communities that value diversity and support wellbeing.

2.3 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 Health and Care Act 2022 mandates that NHS Trusts must consultant and engage with people in hospital and their family and friend carers with relation to discharge. This process will be supported by the Council on an individual basis with relation to its statutory duties under the part one of the Care Act 2014.

3.2 This also forms part of the overall approach outlined in in the Coproduction strategy approved at Committee on 19th December 2022.

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 two) has been reviewed and updated to ensure all available equality and demographic information can help to assess whether (or not) there are any additional inequalities.

4.1.4 The EIA assesses positive impacts, principally in relation to Health, Age and Disability, on the premise that timely hospital discharge home, with any necessary support arrangements in place, promotes recovery, independence and physical and mental wellbeing.

4.1.5 The EIA notes an unintended risk of more pressure being put on carers, but that this should be mitigated by offering timely and thorough Carers Assessments, alongside the person's assessment, to ensure that carers' needs are identified and met as well as the needs of the person.

4.1.6 As more detail of the proposals are developed and implemented, the EIA should be reviewed and updated.

4.2 Financial and Commercial Implications

4.2.1 For 24/25, there is a total of £11,813,909 of joint SCC/ICB Discharge Fund available, managed via the BCF governance process.

4.2.2 Current assumptions are that the Local Authority element of the grant will not be available from 25/26 onwards. Any activity continuing past this point will need to identify alternate funding.

4.2.3 Following submission of the 2023/25 BCF plan three areas were identified locally as requiring additional support to achieve integrated working

- Aligned data sets and reporting mechanisms consistent across organisations.
- Requirement for people and organisational development.
- Financial Review to secure sustainable funding

4.2.4 The financial review includes a new governance process to ensure financial decisions are understood by all partners. A review of current budgets and spend within each discharge pathway is also underway to allow transformation where best value for outcome can be achieved, whilst minimising financial risk.

4.3 Legal Implications

4.3.1 The Health and Care Act 2022 (HSC22) and the Hospital Discharge and Community Support Guidance require Local Authorities 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. It also permits the Secretary of State for Health and Social Care to specify activities that may be delegated between NHS and local authority providers, usually through a S75 arrangement.

4.3.2 The Health and Care Act 2022 amended section 74 of the Care Act 2014 by imposing hospital discharge obligations upon the relevant NHS Trust and the Council retains the care and assessment obligations imposed by Part One of Care Act 2014 (The provisions relating to assessment and then the provision of care). The overall effect is that whilst the NHS has the obligation to care for persons receiving medical care up to the point of discharge from hospital, the Council needs to undertake assessments and provide a care regime during the transition from in-patient care to the service user living in the community. This is the main legal rationale for this contract

It is understood that the Committee has already approved the current contract, and that the requirement for approval of the contract extension arises in consequence of the extension being *a variation to an existing*

4.3.3 *commission or purchasing decision) where the budget* is *reserved to a Policy Committee.* The precise legal gateway for that extension will depend upon the terms of the contract and the applicable procurement regime. In this case the fact that this is a service that interacts with those receiving NHS medical care suggests that this is a Provider Selection Regime (PSR) contract, and any modification (which includes extension) would be permitted under Regulation 13 . The need for the extension appears to relate to the need to plan the new service, which would be a permissible ground under Regulation 13(1)(d) provided the value did not exceed 25% of the original contract total.

4.3.4 The terms of the proposed new contract remain to be explored and it is likely that procurement will be under the PSR. It may well be advisable at this stage to consider whether the new service requires a separate Section 75 agreement with the relevant acute Trust or ICB to facilitate co-delivery, although it is possible that this is already covered by the current BCF S75 arrangements. It will also be necessary to conduct some legal due diligence on where the service sits within the S74 responsibilities and delegations approved by the SHSC for this purpose in order to establish that the Council has the necessary legal powers.

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. Page 47 Page 10 of 10 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.

4.4 Other Implications

4.4.1 None noted

5. ALTERNATIVE OPTIONS CONSIDERED

5.1 Not Providing an Extension – Not providing an extension to the Somewhere to Assess Short Term beds whilst work is underway to deliver future proposals may mean that, sufficiency is not available for discharge post September 2024.

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.

6.3 The extension to the Short-Term Beds Contract by 6 months will enable the review of commissioned beds to be undertaken, a model proposed for Committee subsequent approval and retender completed.

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