Sheffield HCP Priority Programme Brief

Priority Programme Title – Sheffield Discharge Model development	**Reference No.**	n/a
Place Team and Governance	Sheffield Urgent and Emergency Care Delivery Group	
Place Leads	Ian Atkinson – Deputy Place Director Sheffield (interim) Alexis Chappell – Director of Adult Social Care Sheffield City Council Michael Harper – Chief Operating Officer – Sheffield Teaching Hospitals	
Project Leads	Sarah Burt - Deputy Director of Commissioning Development (Planned Care) – SY ICB Sheffield Place Helen Kay – Operations Director – Sheffield Teaching Hospitals' NHS Foundation Trust Janet Kerr – Deputy Director of Adult Social Care – Sheffield City Council Vicki Leckie – Deputy Chief Operating Officer - Sheffield Teaching Hospitals' NHS Foundation Trust	
Clinical & Professional Lead	Dr StJohn Livesey – Clinical Director Sheffield Place Team	
National NHS Objective 23/24 – 31 metrics	The work to improve discharge out of hospital will crosscut a range of national planning metrics, in particular it will support the key urgent and community indicators associated with the 23/24 planning requirements.	
Date Completed	20th May 2023	

Project/Pilot Aims	To work with partners across the Sheffield HCP to reduce delays in discharge from Acute and Mental Health Beds. Implement home first principles across the city including roll out of the optimum model discharge to assess, including acute, community including acute, community and adult social care. Improve patient experience and outcomes through appropriate and timely discharge and recovery in a person's own home.
Rationale	As a system we are currently faced with several challenges when trying to discharge people who require additional support:

	- We have delays within discharge pathways that mean people are unable to be discharged in a timely way when they no longer require an acute bed; - There are process inefficiencies in the system which mean that individuals referred to community services are not ready for discharge, which loses homecare hours to the system; - These delays and inefficiencies mean people and their families do not have positive experiences of discharge and this in turns impacts on our admission to hospital settings for people who have acute health needs; - Delays within hospital pathways mean that discharge cannot be proactively planned accurately; - Lack of confidence – historical lack of trust and confidence across community and acute staff, which then impacts on integrated operational activity and working; - Lack of proactive planning of discharge results in lack of timely communication to community providers regarding capacity/resource requirements which in turn results in further delay.

Project Time Frame					
Start date	May 2023	**End date**	September 2024	**Review period**	Monthly via UEC Group

Project Team	**Role**	**Time Commitment**	**Oversight**
Ian Atkinson	SRO (exec lead)		Sheffield Urgent and Emergency Care Delivery Group reporting up to the Sheffield Oversight and Transformation Committee and escalating as required up to the Sheffield Health and Care Partnership Board
St John Livesey	SRO (clinical lead)		
Michael Harper	STH Exec Lead		
Alexis Chappell	Director Adult Service Care - SCC		
Sarah Burt	ICB Place Lead- Discharge Delivery Group		
Helen Kay	STH Community Lead- Discharge Delivery Group		
Janet Kerr	SCC Delivery Lead - Discharge Delivery Group		
Vicki Leckie	STH Acute Lead- Discharge Delivery Group		

Project/Pilot Objectives (SMART)

Our whole plan aims to remove the queue for discharge in adult Acute and Mental Health services and then sustain all discharge pathways with low levels of medically fit for discharge, no criteria to reside.

- Focus on in-hospital flow including transport and meds optimisation;
- Ensure all partners adopt the ‘home first’ discharge to assess principles;
- Enhance existing discharge hub to create a community reception service;
- Enhance community services to ensure capacity to undertake assessment in the community

- Target Better Care Fund investment for discharge at schemes that support and maintain sustainable discharge to assess;
- Deliver Domiciliary Care provision that supports 'independence' not 'dependence';
- Increase capacity in home care to remove the queue;
- Increase virtual ward capacity to support early supported discharge and avoidable admission.

Project Scope	
Project scope - In	**Project Scope - Out**
For the purpose of this work **all discharge** activity related to Acute and Mental Health provision categorised as pathway 0 – 3 in scope.	

Benefits	Impact/Outcomes	Stakeholder
What is the benefit	*What is the impact/outcome*	*Who benefits*
A higher percentage of patients returning to normal place of residence in a timely manner	- Reduced reliance on bed-based intermediate care - Improved patient outcomes/ satisfaction (to be tested)	- Patients - Families - STH - ICB - SCC
By expediting discharge, we will reduce the length of stay in hospital (Acute and MH)	- Reduced reliance/spend on surge capacity in STH - Reduced LoS in acute bed - Less delays at "front door" at during periods of high acute demand - Improved flow - Reduced patient deconditioning/ infection risk	- STH - YAS - ICB - SHSC - Patients - Families
Improve efficiency of community services by ensuring only MFFD accessing services.	- Less wasted community capacity	- SCC
Improve efficiency of transport as part of discharge	- Patients able to leave hospital when deemed medically fit and where possible in morning to optimise assessment at home	- Patient - Family - YAS - SCCCC - STH
Through regular assessment and review, reduce the number of and length of Home Care Packages	- Delivery of care according to need - More efficient use of spend on care - Care capacity available to support discharge pathways	- SCC

High Level Milestones	Measure	Implementation	RAG rating	Task owner
Establish Discharge Delivery Group and confirm governance arrangements	**Meeting structure in place as per agreed model**	**Complete by end of May 2023**	**Green on track**	**Ian Atkinson / Sarah Burt**
Work to ensure colleagues working within organisations fully adopt the model of discharge that has been agreed	**Achieve both clinical and managerial buy in across teams**	**Complete by end of May 2023**	**Green on track**	**SB /JK/HK**
Identify resource required to enable the delivery of the programme (BCF)	**Agree first draft of Better Care Fund utilisation**	**Complete by end of June 2023**	**Green on Track**	**IA/AC**

Establish capacity of care required and commission to eliminate pathway 1 delays	**1. Modelling completed 2. Commissioned capacity in place**	**1. Complete end June 23 2. By December 2023**	**Green on track** **Will follow from modelling**	**AC/JK/CG**
Establish capacity of care required and commission to manage pathway 1 ongoing (once queue reduced)	**1. Modelling completed 2. Commissioned capacity in place**	**1. Complete end June 23 2. By December 2023**	**Green on track** **Will follow from modelling**	**AC/JK/CG**
Establish Integrated Care Transfer Hub	**Integrated Care Transfer Hub in place**	**TBC**		**Delivery Discharge Group**
Establish community assessment capacity	**Community assessment capacity in place**	**TBC**		**Delivery Discharge Group**
Service lead engagement event	**Event completed, service leads support delivery**	**End of June 23**	**Green on track**	**Delivery Discharge Group**
Acute and primary care engagement event	**Event completed, discharge pathway work aligned to acute internal efficiency programme**	**End of July 23**	**Green on track**	**Delivery Discharge Group**
Paper describing SHSC discharge delay challenges and supportive work programme required	**Paper completed and presented to UEC Board**	**End of August 23**	**Amber further work to do**	**SB / HB / SHSC/ SCC**
Establish "one version of the truth" discharge pathway data for Sheffield	**Dashboard in place**	**December 23**	**Amber further work to do**	**Delivery Discharge Group**

Additional Resource Required
Project delivery Currently the programme is being delivered through existing staffing resource and colleagues being mindful of running cost reductions, the ICB place team have freed up capacity internal to offer project support, STH and SCC have agreed to recruit to joint operational posts and if required we have identified up to 2% administration costs from the 23/24 Discharge Funding allocation that can support. Linkage to the Same Day Access priority work and the development of the primary and community MDT working model being developed by the Primary and Community Care Delivery Group.

Finance *(please provide high level estimates at this stage)*			
SEE APPENDIX 1			

Interdependencies
- Same day Urgent Care work (Priority 1) UEC Group - In Hospital Flow work programme (priority 2 of UEC Group) - Winter Planning 23/24

Communications Plan
- Communications to teams via Discharge Delivery Group - Wider public communication not required at this stage

Public Engagement Plan
Not required at this point as not currently deemed as major service change, more focused on optimising pathways. If at a point in time any specific service changes result in the requirement to engage, we will do so accordingly.

Risks	
Risks	**Mitigation**
Unable to deliver Integrated Care Transfer Hub with necessary assessment and care capacity by Winter 23/24 significantly affecting system resilience at times of surge	- Robust programme management approach - Clear route of escalation/governance/reporting
Adverse patient/carer reaction to streamlined pathway	- Development of clear patient/carer communications to manage expectations of discharge process - Clear messages re patient benefits to hospital workforce
Workforce fatigue means teams may be less receptive to change (acute staff may not welcome faster turnover of patients resulting in perceived higher dependency overall / community may feel will be receiving patients who are more dependent)	- Work with teams to involve in design/delivery - Creation of opportunities for staff to feedback experiences - Ensure feedback loops in place to enable staff understanding of patient/system benefits - Should increase staffing per ward as surge areas close
Unable to recruit to key roles within the programme/ discharge work	Work with partners to maximise recruitment opportunities
D2A services unable to engage fully as continue to plan on paper following cyber attack	Support for new technology enabled solution to free capacity for involvement/increase team efficiency
Intermediate Care national guidance/specification due to be published in September 23 and could distract from Sheffield priority areas	Monitor progress on development prior to publication to assess potential impact

Supporting Information
Discharge strategy – April 2023 Paper-F-System-Approach-to-Discharge-Pathways-Redesign.pdf (sheffieldhcp.org.uk)

Appendix 1 – Finance and Impact

Plans for 23/24

- **Remove the 'discharge queue'**
- Development of a community-based fully Integrated Care Transfer Hub **'community reception service'**
- Embed **D2A** 'home first' model.
- Use BCF ££ to increase capacity to support assessment function in the community
- Improved processes and practice to reduce delays across acute and community settings
- Maximise use of Tech Enabled Support
- Integration of IC, reablement/rehabilitation Integrate bed-based IC offer to include S2A community assessment
- Developing robust data capture including PROMs, PREMs and workforce satisfaction
- Integrated and co-designed approach with Voluntary, Community sector providers
- Maximise the options of direct payments and personal health budgets

Expected Impact on (to be quantified):

- No of occupied bed nights (for NEL care) will reduce
- Number of intermediate care beds required will reduce
- Number of S2A beds required expect to reduce
- Number of palliative care packages
- Reduced level of home care packages – number and duration

Sheffield Health and Care Partnership

Summary of indicative allocations to support Urgent care pathways and discharge improvement 2023/24

	Funding Streams available in 2023-24					
Scheme Name	**Capacity Funding (NR) (£'000's)**	**ASC LA Allocation (£'000's)**	**ASC ICS Allication (£'000's)**	**Virtual Ward Allocation (£'000's)**	**Additional Funding Bids (NR) (£'000's)**	**Total Require-ment Identified (£'000's)**
Voluntary Sector wrap around support	-	-	150	-	-	150
Expansion of technological discharge productivity, support, self-care and brokerage	-	300	100	-	-	400
Additional round of NVS to support homecare discharge	270	-	-	-	-	270
A&E/Orthopaedic clinic based SDEC at STH	430	-	-	-	-	430
Additional Surge Wards to flexi to demand	1,881	-	-	-	1,000	2,881
Virtual Ward Programme	-	-	-	3,614	-	3,614
Advanced Practitioners	-	-	-	-	263	263
ARI services	-	-	-	-	525	525
Clinical Assessment Services	-	-	-	-	250	250
Expansion of Citywide alarm operating hours	-	-	-	-	300	300
Primary Care services to support within 30 days of discharge	-	-	121	-	129	250
Administration and BI support (2%)	-	82	61	-	-	143
Home Care Capacity	-	2,429	-	-	-	2,429
Expansion of social care strength-based review team	-	610	-	-	-	610
Same day equipment and bariatric equipment	-	340	-	-	-	340
Specialist teams (including dementia support)	-	345	800	-	-	1,145
Discharge Hub Set Up including specialist MH/LD	-	-	860	-	-	860
Winter capacity reserve - IC/assessment beds	800	-	-	-	-	800
Winter Capacity Contingency	-	-	974	-	-	974
Total Identified	**3,381**	**4,106**	**3,066**	**3,614**	**2,467**	**16,634**
Indicative Budget Available	**3,381**	**4,106**	**,066**	**3,614**	**2,467**	**16,634**