A SYSTEM APPROACH TO DISCHARGE PATHWAY RE-DESIGN

SHEFFIELD HEALTH AND CARE PARTNERSHIP BOARD

18 APRIL 2023

Author(s)	Place Partners
Sponsor	Ian Atkinson (Deputy Place Director Sheffield ICB), Michael Harper (Chief Operating Officer STH), Alexis Chappell (Strategic Director of Adult Care and wellbeing SCC) and Dr StJohn Livesey (Clinical Director Sheffield ICB)

Purpose of Paper

The Sheffield Place urgent and emergency care strategic plan comprises three key elements. Work to improve:

- Pathways into UEC and the "front end" of the pathway;
- Internal hospital flow; and
- Out of hospital/discharge pathways.

The purpose of this paper is:

1) To make recommendations for a system approach that will deliver short, medium, and long-term benefits to discharge and flow across the Sheffield place, through a coordinated series of changes in process and practice and the redesign of our discharge pathway.

2) These proposals/recommendations should be viewed as a fundamental part of the dynamic system re-design required to ensure that workforce capacity and capability exists to enable the right care in the right place at the right time based on patient need.

3) Propose a high-level plan for improvement in reducing the number of people with no criteria to reside (NCTR).

Key Issues

The narrative presented is based on recent discussions at the Sheffield System Discharge Implementation Group (SSDIG), the Sheffield Place Urgent and Emergency Care (UEC) Delivery Group and Adult Health and Social Care Policy Committee and describes the discharge work to date and the progress made over the last few years.

It describes the short and medium terms plans for improvement in the redesign of capacity and support to fully embed Home First Discharge to Assess principles. It does not reflect all the services included and schemes of admission avoidance that would also be required in a well-functioning urgent and emergency care system for Sheffield. This paper focuses upon the discharge pathway work and if approved, further supportive papers will articulate further detail including the investment required to support.

The recommendations build on the previous work undertaken in Sheffield, learning from elsewhere and on the progress made to date and aligns to national guidance. The paper makes recommendations for a phased programme of work, linked to the wider commissioning intentions and transformational changes in e.g., commissioned home support that will continue to target actions to reduce the current delays.

In the longer term, the development of an optimally functioning urgent and emergency care system in Sheffield will bring together schemes for discharge pathways, admission avoidance, the building of capacity and capability in primary and community care, the use of technologies etc.

Is your report for Approval/Consideration/Noting

Sheffield Health and Care Partnership Board is asked to approve the recommendations set out in the report.

Recommendations/Action Required by the Sheffield Health and Care Partnership Board

It is recommended that the Place Partnership Board:

- Approve the proposed model for Home First discharge to assess as proposed;
- Approve the development of a discharge programme and delivery structure with representation from key stakeholders, that will report to the Sheffield UEC Group to enable rapid decision-making and progress;
- Approve the recruitment of a dedicated Discharge Programme Management resources, using ICB and BCF discharge funding to lead the programme and work across the health and care system in Sheffield;
- Agree that a dedicated programme budget is identified to support delivery in 2023/24;
- Agree to receive a further paper articulating the focus of the programme to Winter 2023/24 to maximise impact in the short term;
- Note the links and interdependencies between this work and other initiatives that support admission avoidance/early supported discharge and to the Adult Care Strategy and Health and wellbeing board strategic intentions;
- Note that approval will also be sought from Adult Health and Social Care Policy Committee given potential implications for adult social care services of the new model and improvement plan;
- Agree to receive regular updates on progress;
- Agree to the proposed improvement plan;
- Agree that within the governance structures outlined, assurance will be gained on best use of Better Care Fund/UEC funding to achieve the model described.

What assurance does this report provide to the Sheffield Health and Care Partnership Board in relations to the ambitions of the Health and Wellbeing Strategy 2019-2024

	Please ✓
Every child achieves a level of development in their early year for the best start in life	
Every child is included in their education and can access their local school	
Every child and young person has a successful transition to independence	
Everyone has access to a home that supports their health	
Everyone has a fulfilling occupation and the resources to support their needs	
Everyone can safely walk or cycle in their local area regardless of age or ability	
Everyone has equitable access to care and support shaped around them	✓
Everyone has the level of meaningful social contact that they want	
Everyone lives the end of their life with dignity in the place of their choice	✓

Are there any Resource Implications (including Financial, Staffing etc)?

Yes. Further detail on any resource required to support the plan will be presented within future papers as detailed plans are developed.

Have you carried out an Equality Impact Assessment and is it attached?
An EIA has not been completed at this stage but will be completed as a priority if/when the proposal has been supported.
Have you involved patients, carers, and the public in the preparation of the report?
Individuals and carers voice will be key to ensuring the co-design of a robust discharge offer and will be included in future papers.

A SYSTEM APPROACH TO DISCHARGE PATHWAY RE-DESIGN

SHEFFIELD HEALTH AND CARE PARTNERSHIP BOARD

18 APRIL 2023

1. Introduction

1.1 Background and Context

At the start of the Covid 19 pandemic in March 2020, the national response and focus was to reduce the burden on the NHS and free up all available hospital capacity. New national guidance was implemented, and systems incentivised with additional funding to progress at pace and further accelerate Discharge to Assess arrangements. The expectation is that patients who are clinically ready can be discharged/transferred within two hours including those who require care and support to return home or move to the most appropriate setting until an assessment of their longer-term needs could take place.

Against the backdrop of new and emerging policies, the Sheffield place has already made progress through system wide collaboration and has already adopted the working principles of 'Home First' with the aim where possible to assess someone's longer term needs only after they have had the time to recover in a familiar surrounding or in a setting away from a hospital ward. Sheffield has a good cultural understanding of the importance of Home First and were the front runner of the D2A model but has struggled to maintain the capacity for delivery nearly 10 years on. Its of note that Sheffield continues to benchmark regards national indicators as recently highlighted in the Better Care Fund reports to Committee and Health and Wellbeing board.

Various programmes of improvement work to support integration have taken place over recent years and in February 2020, approval was given for the redesign and transformation of intermediate care and new models of care to support care outside of hospital. Subsequently, approval was provided in February 2023 by the Adult Health and Care Policy Committee to undertake a further review of the model and improvement plan. The link to the report is here:

https://democracy.sheffield.gov.uk/documents/s57438/8.%20Report%20to%20AHSC%20Committee%20-%20Hospital%20Discharge%20and%20Urgent%20Care%20Delivery%20Plan.pdf. The pause in 2020 was due to the pandemic focused the system to prioritise actions in response to the operational demands, however the implementation of the new hospital discharge operating model providing further opportunities to progress work at pace helped to deliver improvements in processes and practice to improve timely discharge.

The Sheffield System Discharge Implementation Group (SSDIG) was established to oversee the implementation of the new hospital guidance and ring-fenced national funding for hospital discharge. The relationships developed working through the challenges of the pandemic and the relationship with the provider market has been crucial to understanding the challenges as the system recovers from the pandemic. Despite the good work and recent improving position, Sheffield is still experiencing delays in people being able to return home from hospital. The ongoing issue of balancing operational priorities, against tactical and strategic planning have made it difficult to create capacity to support strategic development. A recent bid to NHS England for improvement support was not accepted and this has been raised national meeting.

However, locally a focus has been on our improvement planning and recent ringfenced investment has provided an opportunity for a more innovative approach and to 'test' alternative solutions, eg; "1600 hours", additional night care visiting, expansion of voluntary sector discharge support.

This learning and the now well- established partnerships provide an ideal platform for a more ambitious approach and will help with the implementation of the required changes to our local system offer.

NHS England published its [Delivery Plan for Recovering Urgent and Emergency Care Services] in January 2023. It outlines a multiyear approach to recovering UEC performance and cites five key areas for improvement. These include improving discharge, growing the workforce, and expanding out of hospital care with improved patient flow being identified as a key deliverable. The plan describes the need to improve discharge by:

a) Improving joint discharge processes;
b) Scaling up intermediate care;
c) Scaling up social care services;
d) Involving patients and carers in assessment.

This paper is the first in a series of papers to be developed that describe the three key elements of the Sheffield Place urgent and emergency care strategic plan. These focus upon a) the pathways into UEC and the "front end" of the pathway b) internal hospital flow and c) out of hospital/discharge pathways. This paper focuses upon improving joint discharge processes.

The Health and Care Act 2022, s91 made changes to the legislation which included involving patients and carers in the assessment for discharge. It sets out that if a relevant trust is responsible for an adult hospital patient and considers that the patient is likely to require care and support following discharge from hospital, the relevant trust must, as soon as is feasible after it begins making any plans relating to the discharge, take any steps that it considers appropriate to involve the patient, and carer in in plans. Although, guidance is being developed nationally, locally we are embedding this as part of our new model development.

2.0 What is the problem we are trying to solve?

The challenge to maintain and increase capacity in care to meet demand have been exacerbated by the pandemic and the ongoing challenge of managing IPC in both acute and community settings temporarily impacts on flow due to the closure of wards and community settings.

Over the past year the homecare market both internal and external to the council has undergone a period of transformation, which has increased the number of hours available from council services by 500 from January 2023 and stabilised the homecare market in advance of a new ten-year enablement focused contract going live from September 2023. Alongside this, resources have been put in place in relation to care at night and assessment and care management which has also led to a reduction in delays for those reasons and waits for access to services.

Whilst most patients admitted to hospital return home with no additional support, some people including our frail and vulnerable and those with specific physical and mental health conditions do require additional care and support to return home. This can come from a range of services such as short-term support with rehabilitation at home or in a care setting, help to recover and or help to adjust following a period of ill health.

The resources and processes required to provide an assessment at home on the day of discharge and provide the right level of care and support short term at home in the model proposed will require additional resourcing to meet the targets proposed. Currently packages of care must be determined and secured whilst someone is still in an acute setting, with the assessment taking place in the days following their discharge.

This 'Assess to Discharge' approach means that there are delays whilst a date to return home or move on is secured, there is then the potential for over subscribing the type or level of support required and an overreliance on statutory support. If support is not reviewed within the days or first couple of weeks this can build a reliance of a service for the wrong reasons.

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 means that individuals referred to community services are not ready for discharge, which loses homecare hours to the system;
- These delays and inefficiencies mean people do not have positive experiences of discharge and this in turns impacts on our admission to hospital settings;
- 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.

As a result of the issues outlined above, the system is allocating very significant amounts of additional resource to support "holding" patients in the wrong setting, which creates a high risk of deconditioning and deterioration in our most vulnerable jeopardising their ability to return home, demoralises our extremely tired and stretched workforce and provides a poor experience for patients and their families.

3.0 The Proposed Way Forward

For most people who have additional support needs following the completion of their acute hospital stay the best place for them to continue receiving the care and support needed is their **own home with visits from health and care staff**, from family or other community partners or a combination of several elements to meet their needs whilst they recuperate.

Discharge To Assess means that 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 optimise:

- health and social care outcomes;
- outcomes for people, their families, and their communities;
- workforce capacity and effectiveness;
- value for money;
- our ability to reduce/avoid re-admission.

Figure 1 below describes the four patient pathways within a discharge to assess model. Under the model, 95% of people over the age of 65 who are admitted to hospital would be able to go home. 50% can go home with minimal or no support, 45% can go home with support from community

service (social care/health), around 4% will need short term rehabilitation in a bedded setting (step down) and only 1% should require long term residential or nursing care home.[1]

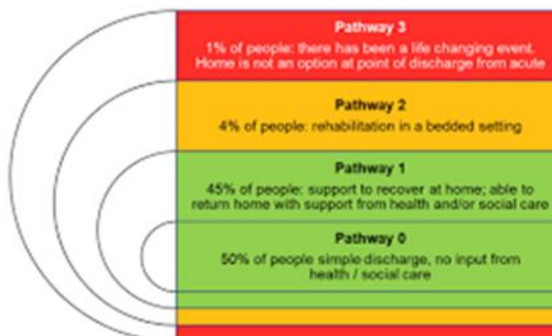


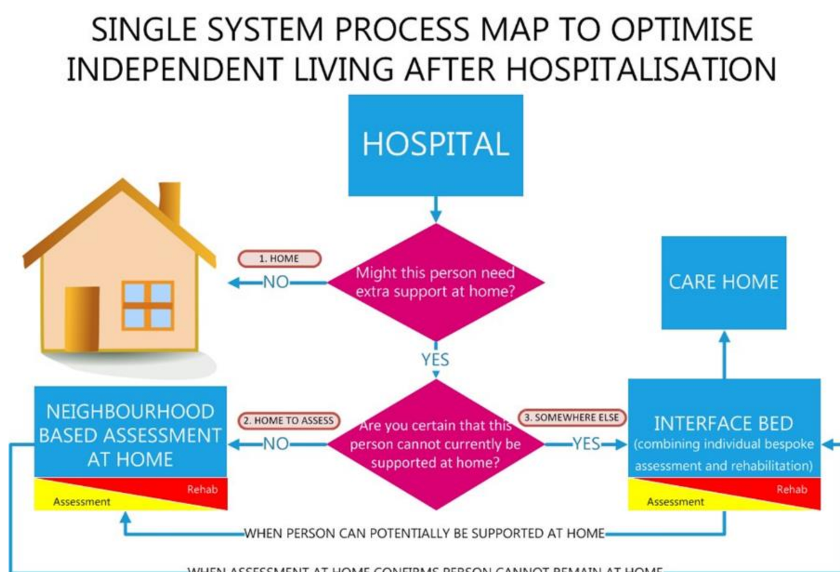
Figure 1: Discharge to Assess model

4.0 Getting it Right – Redesigning the System

D2A is not a new concept and has been a shared ambition of system partners for some time. Timely discharge of patients on completion of their acute hospital care (no criteria to reside) has mutual system wide benefits:

- Reduces the risk of further deconditioning in physical and cognitive ability;
- Reduces the risk of further exposure to infection;
- Improved outcomes and patient and experience – return to a familiar setting reduces anxiety and uncertainty (including family carers);
- The wider benefits of recovery at home or in a suitable alternative setting for a short time;
- Assessment of ongoing needs only after a period of individual recovery;
- Avoids oversubscription of care and support and maximises use of other community networks (VCS etc);
- Reduces the risk of failure demand.

Figure 2 The diagram below illustrates a high-level overview of the process.



[1] Adapted from John Bolton model for persons aged 65 and over, and when used across all 18+ age groups, it is expected that a greater percentage than detailed will be allocated to pathways 0 and 1.

We are no longer experiencing seasonal surges as we have done over previous years and although we are seeing an improved position this remains precarious. Our progress has shown there are some critical elements and enablers to getting this right.

Sheffield needs to implement a recovery and outcome focused D2A model that allows people to be in the best place to support their recuperation and reduces the long-term care costs overall. Similar work has been done before within frailty within the Right First Time Programme and demonstrated that it can be done with impressive results and as then, this will require system wide support; recognising that the benefits if we get it right are many and widespread.

Previous learning has demonstrated that the importance of eliminating the "queue" cannot be overestimated if we are to realise all the benefits associated with the D2A model.

Integrated approaches to discharge planning – the critical elements

Sheffield has previously completed an extensive programme of improvement towards the integration of reablement and rehabilitation support and although good progress has been made, operational boundaries and processes still build in delays with referrals and handoff between providers.

If we are to fully implement D2A in Sheffield, there are some critical elements:

- Strong strategic leadership, governance, and system oversight;
- Dedicated programme resource to ensure deliver of critical timescales and milestones;
- Planning around the needs of the person and their carers;
- A multidisciplinary approach, integrated and whole system focusing on goals and outcomes for people and their carers;
- Embedding a culture of discharge is as important as admission and starts from day one, reinvigorating "why not home, why not today?";
- Clear communication with patients and families to ensure all parties have clear expectations and information;
- At the point someone is designated "medically fit/no criteria to reside" they should be ready to leave the hospital;
- Discharges/transfers wherever possible should be earlier in the day to enable accurate assessment at home;
- Ringfenced capacity is required to support assessment at home on day of discharge to build confidence in the ability of community to deliver a single D2A pathway out of hospital;
- Ensuring the right level of capacity to support each element of the pathway – we must eliminate the "queue" to maximise gains for patients, workforce and system;
- Integrated approaches to avoid duplication;
- a single version of the discharge dataset across the health and care system aligned to the national and local data reporting priorities;
- The relationship with their provider market is crucial. Understanding the motivation of the market, the current pressures and the opportunities are key;
- It is essential that our collective learning and experiences are reflected in the design going forward. Sheffield has a wealth of experience and expertise on discharge that we need to harness if we are to get it right for people.

Forward Plan – A phased approach 2023/24 and 2024/25

Short Term 2023/24

Following Place Partnership Board approval, we need to:

- Establish a Sheffield discharge pathway programme with SRO, resourced lead clinician, key stakeholders, patient and carer voice and dedicated programme management;
- Align governance of the programme through the Sheffield Place UEC Group;
- Articulate a detailed programme plan with timescales and milestones co-designed with our workforce and patients and carers wherever possible;
- Following engagement, agree exemplar pathways where the D2A approach should be focused upon in the first instance;
- Map interdependencies eg; with the re-procurement of a new model of home support and residential care, redesign of adult care and adult care strategy, the need for an improved offer of community mental health support etc that will require awareness/management.

If we are to maximise impact before Winter 2023/24, we need to deliver some key aspects of the plan before Oct/Nov 2023. This should include but not be limited to:

- The development of a community-based “Integrated Care Transfer Hub” to receive people on transfer from hospital and coordinate assessment, planning, service delivery, review, and withdrawal as appropriate. This will be a Single Point of Contact for assessment and discharge arrangements and an integrated multi skilled team will undertake an initial single assessment of individual needs in a person’s own home or in reach to another setting;
- Involving patients and carers in assessment in line with the requirements of the health and care act 2022;
- Home based rehabilitation and support (including support with re-admission avoidance). The alignment of services providing rehabilitation, reablement and care upon transfer from hospital into the community is essential to ensure an integrated approach around a person and their family;
- Maximising the use of enabling technologies where appropriate for patients and for our workforce;
- Bed based rehabilitation and support whilst an assessment of longer-term care needs is determined (incorporating S2A principles).

Following the release of national intermediate care guidance and specification (expected September 2023), we plan to review the provision of intermediate care in Sheffield however it is anticipated that work will include:

- ➢ The integration of bed-based provision to provide greater flexibility according to patient need;
- ➢ The need for a rapid transfer from community into bed provision for those people who have been assessed at home and are deemed to require bed-based provision before they can return home;
- ➢ The integration of rehabilitation/reablement offer;
- ➢ Capacity for people requiring bed-based provision from the community due to escalating care needs;
- ➢ The review of communications with patients and their families to ensure clarity of expectations;
- ➢ Ensuring robust operating procedures so all parties are clear on what/how they are being asked to deliver;
- ➢ Developing robust data capture including PROMs, PREMs and workforce satisfaction.

Medium Term – 2024/25

- Building on the learning from 2023/24 to consolidate established D2A pathway(s) and develop the plan to embed D2A across all discharge pathways including further work to ensure capacity and capability where it is needed to deliver;
- The delivery of one Sheffield discharge dashboard for the system;

- Integrated and co-designed with Voluntary and Community sector providers including providers of domiciliary home care to ensure people get the right support at the right time;
- Maximise the options of direct payments and personal health budgets – people commissioning and procuring their own service and support;
- Work needs to continue to address workforce challenges, this is fundamental to being able to sustain change within the homecare system to bring more people in to the workforce to deliver the resilience needed longer term;
- Workforce stability means that we can develop a robust workforce development offer to enable a more pro-active, anticipatory, and preventative approach which can help to avoid deterioration and crisis;
- Alignment with the city's neighbourhood agenda over time eg: the consideration of a quadrant model within each locality with greater primary/community control through strong local, integrated teams.

5.0 Recommendations

We ask Place Partnership Board to:

- Approve the development of a discharge programme structure with representation from key stakeholders;
- Approve the supportive governance structures (via UEC Delivery Group – *see Fig 3 below)* the programme needs to enable rapid decision-making and progress;
- Approve the recruitment of a dedicated Discharge Programme Management resource to lead the programme and work across the health and care system in Sheffield;
- Identify a dedicated programme budget to support delivery in 2023/24;
- Agree to receive a further paper articulating the focus of the programme to Winter 2023/24 to maximise impact in the short term;
- Note the links and interdependencies between this work and other initiatives that support admission avoidance/early supported discharge, etc;
- Agree to receive regular updates on progress.

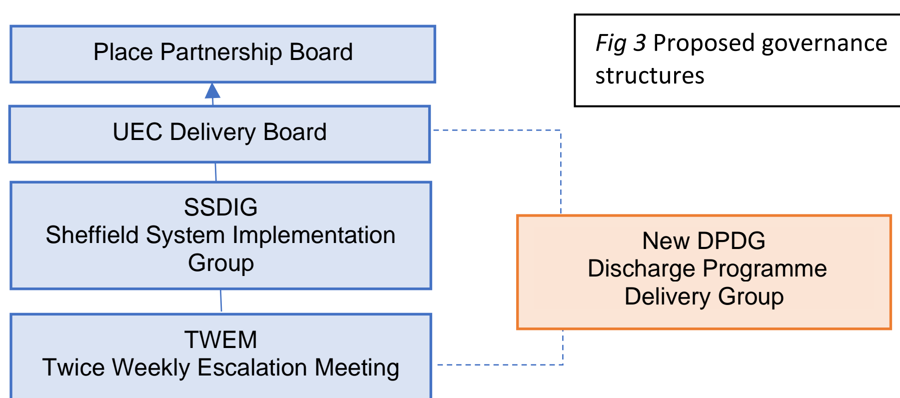


Fig 3 Proposed governance structures