North East
North Cumbria
Health & Care
Partnership

NHS
North East and
North Cumbria

NENC Discharge & Safe Transfer of Care Collaborative

2nd October 2023

Our purpose

North East North Cumbria Health & Care Partnership

NHS North East and North Cumbria

To improve the safety, experience and outcomes of patients being discharged from hospital and transferring their care.

We will do this by:

- Learning together to share our understanding of what works and doesn't work.
- Connecting and building relationships, sharing knowledge, and supporting each other.
- Understanding how we can adapt and adopt good practice.
- Testing out ideas that can lead to a positive difference.
- Using our collective knowledge and experience to solve problems together.

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For today:

- ‘Community focused care – how working together and education enhances the patient journey’ - Catherine Reay and Rachel Daurat, System Co-ordinators - South Tyneside and Sunderland NHS Foundation Trust
- What is our learning from South Tyneside and Sunderland?
- Group activity – What improvement work are you involved in?
- Short update from the region - Catherine Huby, Regional Discharge Lead North East & Yorkshire - NHS England
- Close

'Community focused care – how working together and education enhances the patient journey'

North East North Cumbria Health & Care Partnership

Catherine Reay and Rachel Daurat

System Co-ordinators - South Tyneside and Sunderland NHS Foundation Trust

NHS North East and North Cumbria

South Tyneside and Sunderland
NHS Foundation Trust

Delivering Home First

Challenging risk aversion

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Increased short term demand on care homes

- Demand beginning to challenge capacity
- Increase in new admissions to care homes
- Less people returning to the place they were admitted from

Where did we start in December 2022?

- Integrated Discharge Team in-reaching to the COTE ward as required following ward discharge conversation

- Average length of stay was 14 days

- Discharges by pathway
  - P0 – 10%
  - P1 – 58.5%
  - P2 – 7%
  - P3 – 24.5%

What did we do?

- Allocated 1 Discharge Planning Nurse and 1 Social Worker to begin the discharge conversation at admission with every person and family
- Re-focussed conversations to how people can be supported to return home, especially for ongoing recovery
- Share knowledge and experience of community support available with the ward team
- Supported with the documentation changes in the electronic patient record

Where did we get to by February 2023?

- Average length of stay was 13 days, but did fall to 10 days prior to Christmas

- Discharges by pathway
  - P0 – 23%
  - P1 – 49%
  - P2 – 5%
  - P3 – 9%

  Pathway 0 LOS has reduced by an average of 2 days

Hospital wide adoption

- July 2023 – alignment of Discharge Team to all adult inpatient wards
- Relationship building
- Education
- Increased focus on discharge to home
- Changing the conversation

Progress so far…

- Length of stay

Small reduction for people being discharged on P3

- Discharges per pathway

Marked decrease in P3 discharges, and increase in P1 discharges

Questions and reflections

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Department of Health & Social Care

Department for Levelling Up, Housing & Communities

Local Government Association

NHS England

Transfer of Care Hub

Organisation: South Tyneside and Sunderland NHS Trust

Rachel Daurat, Discharge System Co-Ordinator – Sunderland

Integration and Better Care Fund

Overview

- Team Before Pandemic
  - Sunderland Hospital Complex Discharge Nursing Team based on the wards
  - Hospital Social Work Team based on site however not integrated with health to focus upon discharge

- Team During and After Pandemic
  - Integrated Social Care and Health Care Discharge Team co-located within the main hospital sites in the discharge lounge.
  - No longer ward based on for the Discharge Nurses on both sites.
  - Introduction of the System Co-Ordinator Role as a transformational role across health, social care and associated partners in sourcing services and re-design processes to improve hospital discharge and flow

Method and approach

- **Transfer of Care Hub**

Strive to be a system-level place where all relevant services are linked in order to coordinate care and support for people who need it during and following discharge and to prevent acute hospital admission. The TOCH aims to reduce risks including hospital-acquired infections including COVID-19 and prolonged length of stay in hospital.

  - Enhance the MDT approach – therapy, reablement, Recovery at Home, Homeless Reduction Officer and Age UK presence alongside nursing and social care
  - Streamline processes
  - Raising awareness and training e.g., importance of red2green, discharge to assess

- **Discharge to Assess**
  - Focus upon Home First principles
  - Steering groups facilitated with therapy (acute and community), nursing and social care
  - Re-design of the D2A service has been completed and submitted for approval to be in place before Winter 2023

Method and approach

End of Life Fast track P1

- ICB, ATB and System Co-Ordinator worked together to commence a 3-month pilot of domiciliary care provision for P1 patients who have been granted Fast Track funding.
- Facilitated by TOCH
- One specific agency was commissioned to deliver the service Sunderland wide

Method and approach

- CHC Hybrid Nurse
  - Further to learning and good practice when CHC nurses were redeployed into the IDT, a business case for an 18-month pilot was developed for a CHC nurse hybrid role , working collaboratively alongside the Integrated Discharge Team and Hospital Social work team at SRH.
  - The CHC nurses performing this role are two existing experienced nurse co-ordinators. This will ensure that they remain up to date and rooted within the NHS Continuing Healthcare and Funded Nursing Care Framework.
  - Develop the quality of assessments completed in the hospital in relation to funded care pathway to reduce any delays due to this
  - To support safe and swift MDT decision making in relation to ensuring appropriate category and place of care
  - To review and advise ward staff in the robust monitoring of enhanced observations and support decision making in relation to need upon discharge
  - To act as an educator and advisor to clinicians, staff and patients/families in relation to NHS funded care pathways
  - Joint work with nurses and social care and close working with the Trusted Assessor for P3s

Method and approach

- Shared Workflow Report and Electronic Referrals
  - Developed one report that is distributed to key stake holders with the data being used for Command and Control, operational flow and targeted pieces of work around delays
  - Developed electronic District Nursing referral forms that are pre-populated from patient information system and emailed through to SPOC on the day of discharge.

Successes, measurable impact and quantifiable benefits

- **TOCH**
  - Streamline processes = more effective
  - Therapy presence has been beneficial in addressing situations where patients could be home via D2A
  - System Co-Ordinator has assisted in a helicopter view across partners which supports the ongoing transformational work – community beds, discharge to assess, CHC, 1:1 requests
- **Electronic District Nursing Form**
  - Freed up nursing time to give back to patient care
  - Improved data quality

Successes, measurable impact and quantifiable benefits

- **<u>Community beds</u>**
  - Sunderland has historic reliance upon bed based service
  - On a positive note, this has assisted in more timely discharges for those awaiting a care package given pressures upon domiciliary care
  - Acknowledgment however that there is an impact upon the patient, community services who wrap around these beds and funding day

Successes, measurable impact and quantifiable benefits

- **End of Life P1 pilot**
  - The pilot has been successful in significantly reducing delayed discharges for this client group
  - Supported patients home same / next day where they have expressed their preference to die at home
  - Positive feedback gained from patients, family and wards
  - Plans in place to commission a permanent service delivery
- **CHC Hybrid Nurse Role**
  - Early feedback is already demonstrating positive outcomes in relation to identifying the correct categories of care for patients and the quality of referrals.
  - Future work with ICB, STSFT and Adult Social Care in regards to developing an evidence based practice tool for facilitating discharges for the more complex patients

Challenges

- Organisational protectivity
- Information sharing – separate systems
- Interpretation of data and how this reflects upon organisations
- Joint working
- Developing a shared accurate data report – although this is improving still some work
- Staffing within the IDT to support the visibility, support and education required to support the aims of the Team.

Key learning points

- Organisational trust, transparency and open communication is key to bringing about positive change
- Professional challenge is healthy
- Listen
- Ensuring we are patient focused at times of demand and pressure
- Ensuring the staffing model fits more with the needs of service.
- Ensuring rota’s match demand of peak times

Next steps

- New staffing model to enable area-based support via TOCH
- Streamline processes, e.g., TOCH to directly refer to Rehabilitation beds directly to the provider
- Commence from 4th September the first phase of ward-based Discharge Nurses within Surgical/Orthopaedic areas, with the support of dedicated SW within the Hub Sunderland Patients.
- Roll out the 3 other cluster areas of Sunderland Hospital as new staff join the team from October in readiness for Winter.
- Electronic Referrals for P1 and P2
- Utilise the daily workflow report to address practice across the system to ensure understanding and accuracy

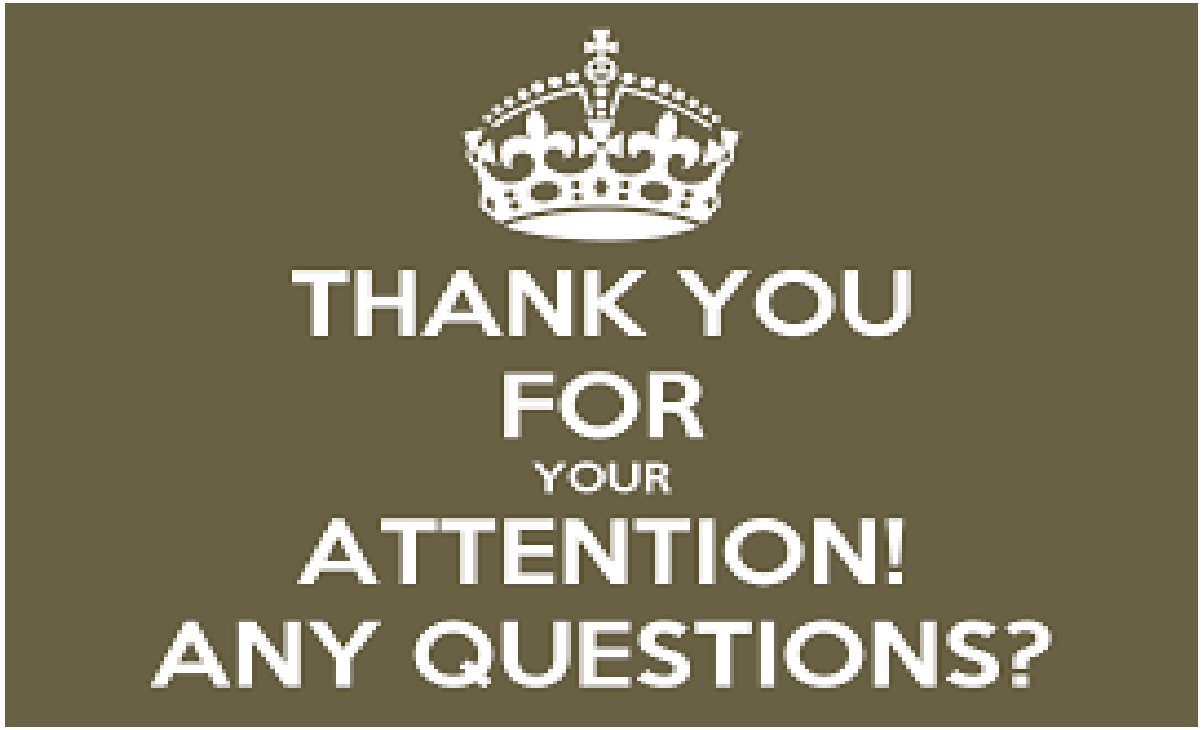
Department of Health & Social Care

Department for Levelling Up, Housing & Communities

Local Government Association

NHS England

The End



Discussion

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What is our learning from South Tyneside and Sunderland?

- What is my role within this?
- Who can I share this with?
- Who else would benefit?
- What does this mean for us as a system? Organisation? And self?

Group Activity

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What improvement work are you involved in that we can capture as part of our collaborative activity?

Please add the work/projects and contact details to your room's Google slide.

Short update from the region

Catherine Huby

Regional Discharge Lead
North East & Yorkshire - NHS England

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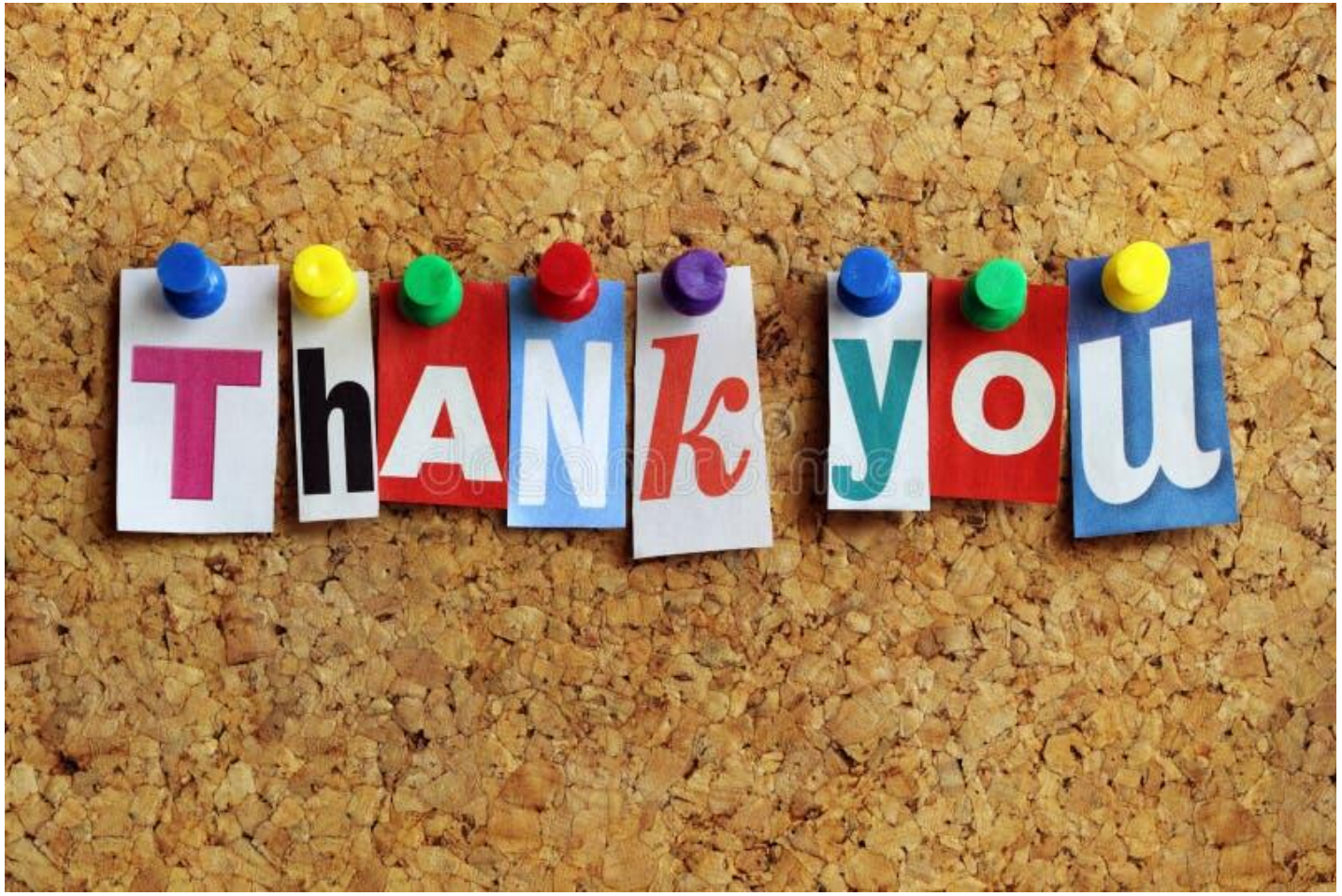

Our next meeting:

Monday 13th November
13.00 to 14.30

Keep in touch

nencicb-cu.learningandimprovementcommunity@nhs.net

WhatsApp