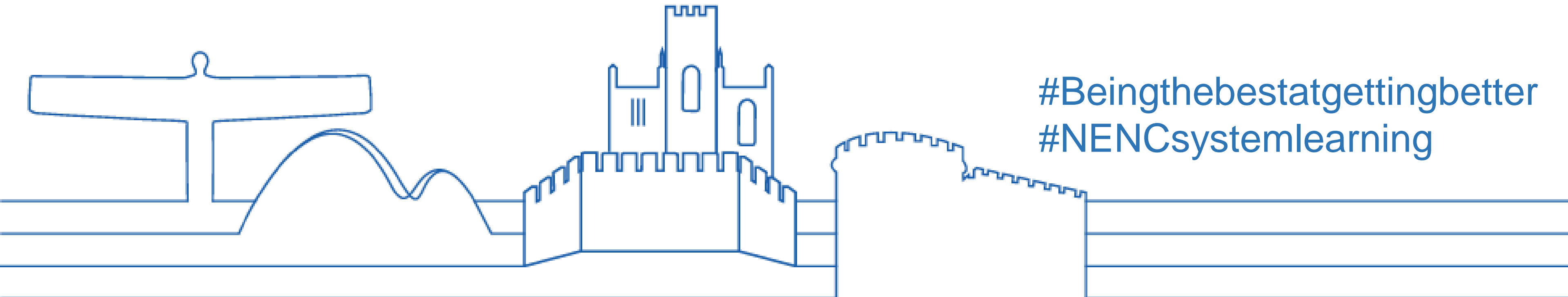
Discharge Summit

North East & North Cumbria

North East and North Cumbria (NENC) Integrated Care Board convened a “discharge summit” on 9th March 2023, 1330-1700.

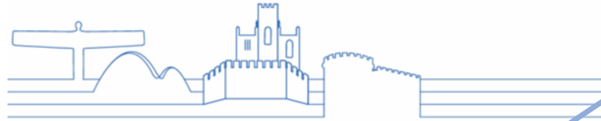
330 people signed up

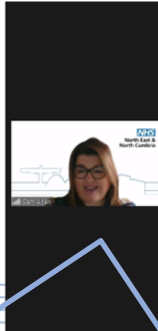
This slide deck is a report on the outputs of the event



#Beingthebestatgettingbetter
#NENCsystemlearning

Sam Allen, CEO of the NENC Integrated Care Board, welcomed participants





The things that really make a difference are not designed in board room meetings, the real magic is in coming together and sharing generously our expertise and experience.

We want these services to be the best they can be.
This is at the heart of why we have committed to becoming a learning and improvement system.

This is an opportunity to make improvements – this learning community makes changes and provides a safe space to fail fast and learn quickly

The next big thing is lots of small things…
We have people here with a huge variety of skills...

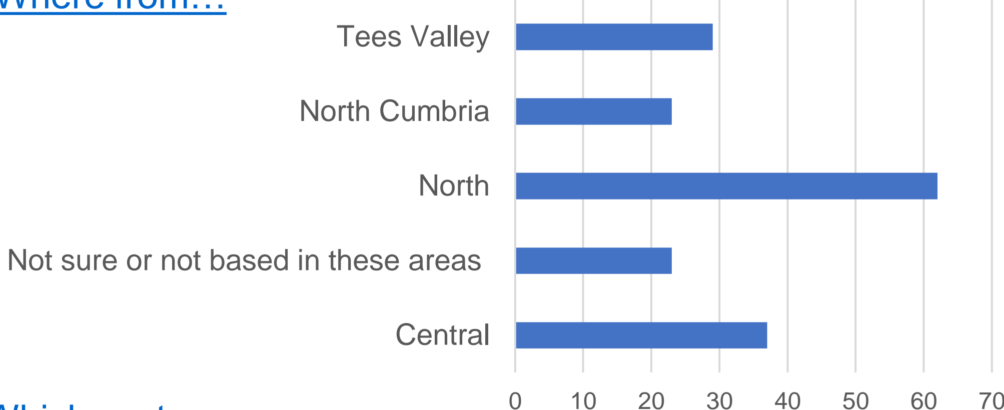
Huge thank you for giving your precious time to be with us during such challenging periods of resources and staff.
Time is one of our most precious commodities.
This is quality time to engage.

The 'best at getting better' is driven out of humility,

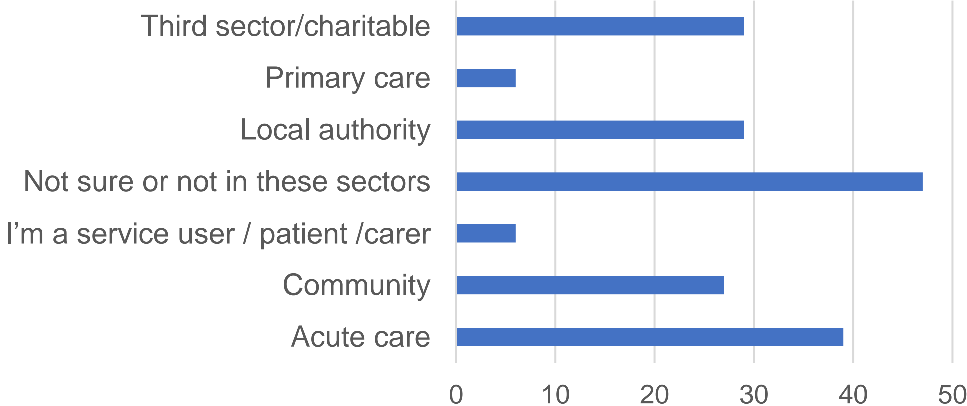
A real sense that everything we do, we can improve upon. We are providing the agency for real change.

The first polls of the event identified where people came from

Where from…



Which sector…



Our aims for the event were to

- learn from each other and to consider how we can improve together to make a difference for our communities
- create a space to bring together people from across North East and North Cumbria with national and international colleagues with experience of improving discharge.
- develop our collective learning through a collaborative approach.

The agenda

Welcome – Samantha Allen, chief executive, NENC Integrated Care Board
Break out session 1: Making connections – why our work today is so important
A short testimony film
Our challenge – David Purdue, executive chief nurse, NENC Integrated Care Board
Expert panel and opportunity for questions
Break out session 2: Hearing from good practice locally, nationally and internationally
Break out session 3: Developing our learning through a discharge collaborative approach
Reflections on the afternoon
Thank you and close

We heard a testimony film to ground the discharge summit in the lived experience of a family who have recently experienced a transfer of care out of hospital

Christine and Michael

Described the experience of their father Jimmy in being discharge from hospital… getting their loved one home and the impact the experience had on their family.
Grounding for all of us – every single statistic is a person with a family like this.

Jimmy Charlton

2 August 1940 – 22 January 2023

David Purdue - Executive Chief Nurse,
NENC Integrated Care Board, described the current situation

The care conundrum

- Acute hospital care for older people saves lives, planned care for older people helps them to remain independent
- Staying in hospital after they are medically fit is hazardous for many older people
- Large numbers of older people stay in hospital longer than they need to because meeting their health and social needs in the community is not possible
- This is a system challenge: no one organisation can solve this but we have a better chance together

The adverse effects of prolonged hospitalisation

- Pre-admission level of independence is lost quickly
- With three or more nights delay, 1 in 10 will suffer actual harm
- With a delay of five or more nights 1 in 5 deteriorate so badly they cannot be discharged
- By 28 days, 1 in 3 suffer harm

Our challenge

- **1,731** people in February 2023 were in a hospital bed in the North East and North Cumbria who didn't need to be there
- It has significant implications for these people and their families: causing emotional, psychological and financial distress
- It adds up to 10.1% more work to a health and care system that is already under pressure

What is the state of 'discharge' care in the NENC ICS and how does it compare with other places?

- Discharge rated on the number of patients who no longer 'meet the criteria to reside'
- Large variation across the system, ranging from 25% to 3% of beds occupied
- Strong comparative performance against regional ICBs

How are our people experiencing discharge?

What must we stop doing?

- Allowing the person to get lost in the overall pressure of day-to-day operations
- Move people to other wards, hospitals or care homes without a discussion with individuals, families or carers
- Keeping people in hospital when they want to and could go home

What should we do?

- Ensure that we provide clear information at all stages of the in-patient stay
- Follow the basics of good discharge: people go home to their own property, with medications and at a reasonable time of the day
- Make sure the planned discharges take place unless the person becomes unwell
- Ensure transfers of care to other providers are accompanied by accurate and up-to-date information relevant to the person being transferred
- Improve the understanding of discharge to assess across our staff and our communities
- Provide every person who is discharged has a named professional who knows about the persons medical care plan and can discuss this with individuals and families.
- Foster a learning environment that is open to feedback and tackles issues

Key Factors in Effective, Safe Discharge

1. Recognition that home is best for the majority of older people leaving hospital
2. Care must be tailored to the needs of the individual and not arranged for organisational convenience
3. All funding options must be available (e.g. personal health budget, personal budget, integrated personal budget, via commissioned services)
4. Constant focus on maximising independence for all in post-discharge recovery and support services
5. Positive, collaborative system leadership with clear vision, trusted by partners, and a determination to solve problems and blur boundaries as necessary
6. Performance metrics must be based for on outcomes for service users - not individual organisational indicators
7. Preparation for discharge begins at the point of admission
8. Good post-discharge care can only be provided by flexible multi-disciplinary, multi-agency working

Improve data accuracy (Use of Optica)

7 day working

Workforce planning

Escalation

Our strategic priorities to improve or services…

Members of our panel made an opening statement on the opportunities to improve things followed by a Q&A

- Annie Laverty – Executive Chief People Officer NENC ICB
- Daniel Cowie – GP, Ageing well, Newcastle
- Jane Hartley - Social Prescribing & Health Partnerships Strategic Manager
- Julie Clayton – Chief Executive, Eden Valley Hospice
- Catherine Monaghan – Consultant Acute and respiratory medicine, North Tees and Hartlepool NHS Foundation Trust
- Levi Buckley - Chief Operating Officer North Tees and Hartlepool NHS Foundation Trust
- Chris Smith – Deputy Chief Executive, 13 Housing Group
- Wendy Lewis – NHSE North England System Improvement Team
- Dale Owens - Strategic Director Adult Social Care, Gateshead Council
- Alys Dean – GP, Northumberland

There was a choice f 14 breakout rooms, sharing local, national and international learning

1	Which behavioural biases might influence the decisions clinicians make about hospital discharge, and how should we address these biases?	**Helen Moore** – Behavioural Insights Team, NHS England
2	Learning from Sweden	**Goran Henriks** – Region Jonkoping Sweden
3	CHS healthcare brokerage service	**Karlie McGahey** – CHS Healthcare **Maria Knowles** – CHS Healthcare
4	Right Time Right Place – Creating a new community model for future demand	**Dale Owens & Vanessa Bainbridge** – NE Association Directors Adult Social Services
5	Personalising care : Learning from carers experience of discharge	**Jane Hartley** – Voluntary Network North East **Kelly Coulter** – Personalised Care, NHS England
6	OPTICA discharge optimisation	**Benjamin Tulloch** – North East Commissioning Support
7	Global good practice in hospital discharge: Learning from the USA	**Christine White** – Cincinnati Children's Hospital, USA
8	The workforce pipeline	**Derek Marshall** – Health Education England
9	An introduction to discharge improvement	**David Purdue** – NENC Integrated Care Board
10	Transfer of care hub	**Sarah Farragher** – North Cumbria Integrated Care FT
11	Keyworker support – supporting discharge for children and young people with a learning disability and/or autism	**Joanne Gilliland** – Cumbria Northumberland Tyne and Wear NHS
12	Support for hospital discharge and community	**Matt Wynne** – Care Group **Levi Buckley** – North Tees and Hartlepool FT
13	CHC nurse hybrid role	**Victoria Playforth** – NENC Integrated Care Board
14	Why is it so hard to get discharge improvement initiatives to stick?	**Kate Pound** – NHS England

Adele Coulthard, Head of System Improvement, NHS England, led the process of getting feedback from the breakout sessions

- “So much energy and so many ideas”
- NENC is really innovating and pioneering on the way it wants to co-create a community, a collaborative to help deal with some of the more tricky issues and priorities the ICB has
- How we can work together on this priority t develop solutions and ideas together?
- This is the beginning of a journey together on a number of themes, help us to to identify what next steps and solutions and ideas
- Stretching boundaries of our ambition
- If there is one place that can innovate and take care of population this this place
- How can we be creative together?
- We want your thinking to develop new ways of doing business
- Are we starting at the right place?
- Don’t be bound by what we already know

What did participants say was needed to take forward a learning and improvement collaboration for improved transfer of care?

- Establish trust, transparency and a readiness to collaborate
- Develop a shared language, moving towards inclusive descriptions such as ‘transfers of care’ rather than “discharge”
- Develop a co-production approach which is focused on people who use services, with voice given to families and unpaid carers
- Use the perspective of people who use services in the context of the continuum of care to consider how we approach shared risk
- Map out known good practice and begin putting the pieces together
- Seek a higher level of involvement of voluntary and community sector and social care leaders

Participants were asked what they would share with others

North East and
North Cumbria

- *Hope - if we can harness this then we can make the change*
- *How do we keep the voices of staff (all sectors) central to developing our approach - enable them to speak direct to leaders about what makes a difference ?*
- *I will take this back into my work with the social work teams around integrated working and person centred approaches*
- *Thinking ' differently' regarding workforce models and regularly challenge whether our approach is still the best*
- *Setting up a Discharge planning meeting . Finding key links in the community. Encourage others to attend future events*
- *That we need to bottle the enthusiasm and energy from these sessions and make sure it drives genuine positive action and cultural change. Otherwise we will be failing ourselves and our patients*
- *Key point from groups about communication, honesty, passion, personalisation, collaboration, use of data, being truly integrated and the need for system wide standards to improve consistency*
- *That we need a change of language and approach and a look at what is happening elsewhere*
- *The importance of joint working, acknowledging that everyone has a part to play. More networking, asking teams to go out and meet other teams across the system*
- *The positivity about a subject which is often seen as insurmountable*
- *The idea from Cincinnati of agreeing a time scale to transfer people out of hospital once they are ready to go "we are we"*
- *I have some new contacts to go and see, to network and learn from those doing things very well*
- *There is definitely an energy here to try a different approach*
- *I have lots of new ideas for taking things forward to share with colleagues. e.g. mini place based person-centred workshops on transfer of care following on from this bringing together local stakeholders*

What immediate actions were identified?

- Follow up event by sharing output report with an invite to attendees to invite feedback
- Establish collaborative meetings – 6 online meetings to share good practice, co-production, and standardisation discussions beginning at the end of April
- Scope and partner with the NENC Academic Health Science network for improvement events at place : 4 area events to inform improvement collaborative
- Work with CEOs regarding leadership and support for collaborative improvement
- Maintain design group to oversee the collaborative on behalf of the learning and improvement steering group
- Apply learning from feedback to future events

What reflections did participants give of the event?

Empowerment and sharing knowledge

Lots of ideas for taking things forward to share with colleagues. e.g. mini place based person-centred workshops on discharge following on from this bringing together local stakeholders

Key point from groups about communication, honesty, passion, personalisation, collaboration, use of data, being truly integrated and the need for system wide standards to improve consistency.

Try to ensure that appropriate conversations are had quickly with all of the MDT including family and carers prior to discharge so that there is no issues raised at point of discharge

There is an energy here to try a different approach

That we need to bottle the enthusiasm and energy from these sessions and make sure it drives genuine positive action and cultural change. Otherwise we will be failing ourselves and our patients.

Step back and think from the patient perspective a little more