

Doncaster Metropolitan Borough Council, Rotherham, Doncaster and South Humber NHS Foundation Trust and Doncaster and Bassetlaw NHS Foundation Trust

## Doncaster integrated working – health and social care in partnership

### Overview

Doncaster Metropolitan Borough Council, Rotherham, Doncaster and South Humber NHS Foundation Trust and Doncaster and Bassetlaw NHS Foundation Trust worked together to improve discharge processes, prevent hospital readmissions and reduce direct admissions into permanent care from hospital. Using Department of Health reablement and readmissions funding, two main changes were implemented: redesign of discharge pathways and introduction of a multidisciplinary 'rapid assessment programme team' within the Emergency Department and Medical Assessment Unit, focused on admission avoidance.

Previously, social care assessments were completed in an acute bed, resulting in delays in the system, duplications of assessment and patients remaining in bed for longer than may have been clinically appropriate. A high proportion of patients were also admitted to long term nursing care post discharge. The system changes implemented included:

- Every patient admitted into hospital is put into a computerised 'i-tracker' system, with an expected date of discharge set within 24 hours
- Healthcare professionals, including GPs have access to 'i-tracker' system to follow pathway of care, and identify reasons for and act on any delays to their discharge
- Patients who are able to be discharged home with support are referred into a single point of contact; a joint health and social care assessment takes place in the patient's own home within two hours of discharge, with support packages in place on the same day. More complex patients are referred into the Integrated Hospital Discharge Team, which works across boundaries over five days with seven day working on the agenda to start in the new year
- Co-located with this team are discharge nurse specialist case managers who manage complex patients and are managed within a single management structure. The nurses work three long days (08.00-18.00hrs), ensuring continuity of handover with the Integrated Discharge Team
- Three assessment units for complex social care needs, two specifically for dementia needs, provide more appropriate assessment of patients within a home setting. This has reduced the number of patients going directly into long term care
- At the hospital front door, the multidisciplinary rapid assessment programme team offers a seven day admission avoidance service, with acute physician consultant support across all days of the week.

### Impact Patient

- There is now more of a patient focus on rehabilitation and reablement, with earlier assessment and intervention and personalised support packages put in place. As a result, patient experience and outcomes have improved
- Prevention of hospital readmissions – since introducing this service, 76% of patients within the Emergency Department or Medical Assessment Unit have had an admission avoided, following an assessment and an alternative community based package of care put in place

- Reduction in direct admissions into permanent care from hospital

### Staff

Integrated health and social care teams have enabled a better understanding amongst professionals of each other's roles and understanding of what can be done.

### Overall system

- Changes in the discharge pathways have reduced delays across the whole system
- No elective cancellations due to reduced delays
- Reduced administrative burden associated with delays in discharges; no section 2s or 5s used
- Reduction in length of stay and occupied bed days. Over a nine month period, 4,176 bed days were saved

### Challenges and solutions

Facilitating changes in staff's working patterns was the most challenging aspect as there was no formal process in place. The discharge case facilitators work three long days, from 08.00-18.00hrs, which has allowed for continuity of handover.

### TOP TIPS

- **Having the integrated discharge team and case facilitators working together under a single management structure has helped support closer working and continuity. The team feel supported, and can escalate if things aren't progressing**
- **Engage commissioners from the start and involve them in the redesign of the pathways**
- **Clear management sign up to support changes**
- **Support of the Clinical Director for Acute Medicine has been key**

### Contact

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