Integrated discharge team enables better outcomes, quicker mental health assessments and timely discharge

- The team works to avoid unnecessary admissions and support timely discharge to the most appropriate setting
- Following the introduction of the team there has been a drop in admissions from A&E, fewer people waiting more than four hours in A&E and more people receiving mental health assessments out of hours

**Background**

There is empirical evidence that too many patients are staying in hospital beds unnecessarily. Often, care can and should be more appropriately delivered in the community rather than in an acute hospital bed, with personalised and effective services in or as close to people’s own homes as possible.

In October 2013, Dartford, Gravesham and Swanley CCG commissioned Darent Valley Hospital, along with the local authority, out of hours GP service and local community and social care Trusts to provide an integrated discharge team (IDT).

**Summary**

- Many patients are in hospital beds unnecessarily when they could receive better care and better outcomes in the community
- An integrated discharge team was created spanning hospital and primary care and bringing together doctors, nurses, therapists, pharmacists, social care workers and mental health specialists
The IDT is made up of doctors, nurses, therapists, pharmacists, case managers and mental health specialists working across acute and community settings. The aim is to ensure that patients receive the most appropriate care, delivered by the most relevant healthcare worker in the most appropriate setting.

In particular, the objectives of the IDT were to:

- Deliver a multi-agency approach to ensure timely discharge and the best possible outcomes for patients
- Ensure timely access to a range of community-based health and care services and the best use of health and care resources
- Avoid the premature or unnecessary admission of patients to acute or long term care
- Reduce the number of re-admissions for patients with chronic long term conditions.

**Action**

Job descriptions and person specifications for the IDT were developed and recruitment commenced. The team consists of:

**Operational clinical lead:** Leads and plans the work of the team, reviewing performance to improve integrated care.

**Integrated therapies and falls service:** Physiotherapists and occupational therapists working together in an integrated therapy team.

**Specialist nursing services:** Proactively supporting patient reviews and joint assessments with the specialist teams in the acute hospital, both on the wards and in the emergency department.

**Discharge coordination nurses:** Work in the emergency department assessing and treating patients and enabling same-day discharge where possible, in addition to supporting timely discharge from the wards.

**Pharmacists:** Join doctors on post-admission ward rounds. The presence of a pharmacist means that they can be involved at the time of prescribing and are aware of patients’ care plans and predicted discharge dates so that medicines can be provided promptly.

**Acute/community geriatrician:** Works across both community and acute settings, including with the IDT in the emergency department. Focuses on admission avoidance by carrying out a comprehensive assessment and providing prompt intervention and tailored support for same-day discharge.

**GPs:** Work at the front end of the emergency department identifying those patients who can be seen by - and discharged safely to - primary care.

**Case managers:** Social care practitioners recruited to work in the integrated discharge team.

**Additional psychiatric liaison:** Specialist mental health assessment service out of hours and at weekends, based in the acute hospital, to reduce delays in treatment for people with mental health problems.

The work of the IDT is underpinned by the principle that discharge planning begins at the point of admission and the development of a ‘one team’ approach and culture.
Physiotherapists and occupational therapists work together in an integrated therapy team. Investment has provided therapists at the front end of A&E who can assess patients fit for discharge home or to an alternative place with support, avoiding unnecessary admissions. They also provide therapy support to reduce lengths of stay and the integrated falls service provides a falls clinic and rehabilitation to facilitate discharges and avoid admissions.

Existing discharge and transfer of care services have been enhanced by developing relationships with mental health, alcohol liaison, nursing and residential homes and community nursing services.

Discharge literature has been developed and produced for patients to assist them and prevent delays. In addition, all staff have received support, advice and training on discharge planning.

**Impact**

Cause and effect are difficult to prove, not least because the IDT is one element of wider system transformation.

However, following the introduction of the IDT:

- There was a decreasing trend in emergency admissions
- There was also a reduction in the number of people waiting more than four hours in A&E
- Timely access to specialist mental health assessments out of hours improved from 20% to 48%
- In the first four months, no one coming through the IDT ended up requiring a move into permanent care.

Engagement with clinicians and communication about the IDT is on-going, but there is already evidence of consultants contacting the IDT prior to admission and good liaison between the IDT and wider community teams.

**Next steps**

All roles and responsibilities for the composition of the team have been evaluated, redesigning the optimal team for continued success.
Further information

Kent integrated discharge team report
www.icase.org.uk/pg/cv_content/content/view/121875/110652?cindex=6

Paramedic dementia training case study which formed part of the Kent integrated programme:
www.nhsiq.nhs.uk/media/2573243/ltc_case_study_paramedic_dementia_training_kent_mh.pdf

North Kent Better Care Fund (of which the IDT was part) case study on NHS England learning environment website
https://learnenv.england.nhs.uk/pinboard/view/118

Contact

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TOP TIPS

- **Developing the team takes time**: Developing the team is critical but takes time. It is easy to underestimate just how much time it will take. Recruitment to some posts took longer than planned and it took time to develop an induction programme and put in place plans for ongoing development.

- **Build buy-in**: Conversations with all stakeholders to listen to their concerns and take on board their suggestions for how the new model might work will help to build buy-in to new ways of working. Engagement and consultation with GPs was crucial to build support for the new service and change practice away from traditional automatic admission for hospital management.

- **Success builds confidence**: Success in delivering better outcomes for patients builds confidence. It helps build trust between professions and individuals who have not traditionally worked closely before and leads to further improvements.

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To find out more about ‘Long Term Conditions’ programmes:
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