Better Together
Integrated Discharge and GP IT update

Helping to shape future health and social care in Mid Nottinghamshire

Integrated Discharge Review

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Aims to provide a summary of current arrangements (including resource analysis, good practice and difficulties), options for change and a recommended way forward in order to deliver the following benefits:

- A more integrated approach: users experience a ‘seamless’ service, with the boundaries of different services not being apparent
- A philosophy of “home first” and a ‘person centred approach
- Significantly improved effectiveness of team and processes so that we have the right capacity in the right place at the right time and system flow improves
- A reduction in time patients spend unnecessarily in hospital (i.e. delayed days) so reducing decline in independence and mobility
- A reduction in readmissions due to ineffective discharge arrangements.
- Analysis of resources utilised across discharge processes to identify the most efficient and appropriate use of resources and options for savings

System Impact – aims

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The overall impact of implementing a fully integrated discharge function will support the following key system deliverables:

- Reduction in non-elective admissions
- Reduction in length of stay
- Reduction in excess bed days
- Reduction in non–elective readmissions for same HRG
- Reduction in demand for long term residential care

High Impact Discharge actions

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Shared commitment to developing a whole system plan, it is recognised this will not be a short term solution

- Immediate actions taken to address constraints impacting on timely discharge and appropriate and effective transfers of care
- Reviewed current service provision for discharges functions
- Service redesign to establish pathways and activity for complex discharges
- Feedback of learning from this will inform future commissioning intentions
- Pilot project to enable front door staff at ED (FIT team) to access social care information directly from Frameworki is recognised as saving staff time and means that relevant information is available at any time of day or night
- Training for ward staff by Adult Social Care on completion of Assessment and Discharge Notices

Progress on longer term model

The key milestones achieved by the project team are:

- Preliminary mapping of existing services and base lining of spend and coverage
- Stakeholder workshops including *Wicked Issues* and Integrated Discharge Visioning events
- Development of high level transformational integrated model by project team from engagement events
- Development of pathways for complex discharges which as well as improving processes will enable activity to be measured

Good Practice Identified

From the engagement events and through engagement with partners the following good practice has been identified to build into the integrated discharge model:

- Utilise learning form the IDAT pilot in Q4 to inform the integrated discharge model
- Build on existing good practice such as the ASSIST scheme from Mansfield District Housing which supports patients with housing needs
- Clinical Assessors in ED provide a conduit to community services, challenging misconceptions, providing insight and support to prevent unnecessary conversion from attendance to admission
- An audit of Continuing Health Care (CHC) and fast-track patient notes was carried out in January 2017 learning from is being used proactively

Work streams

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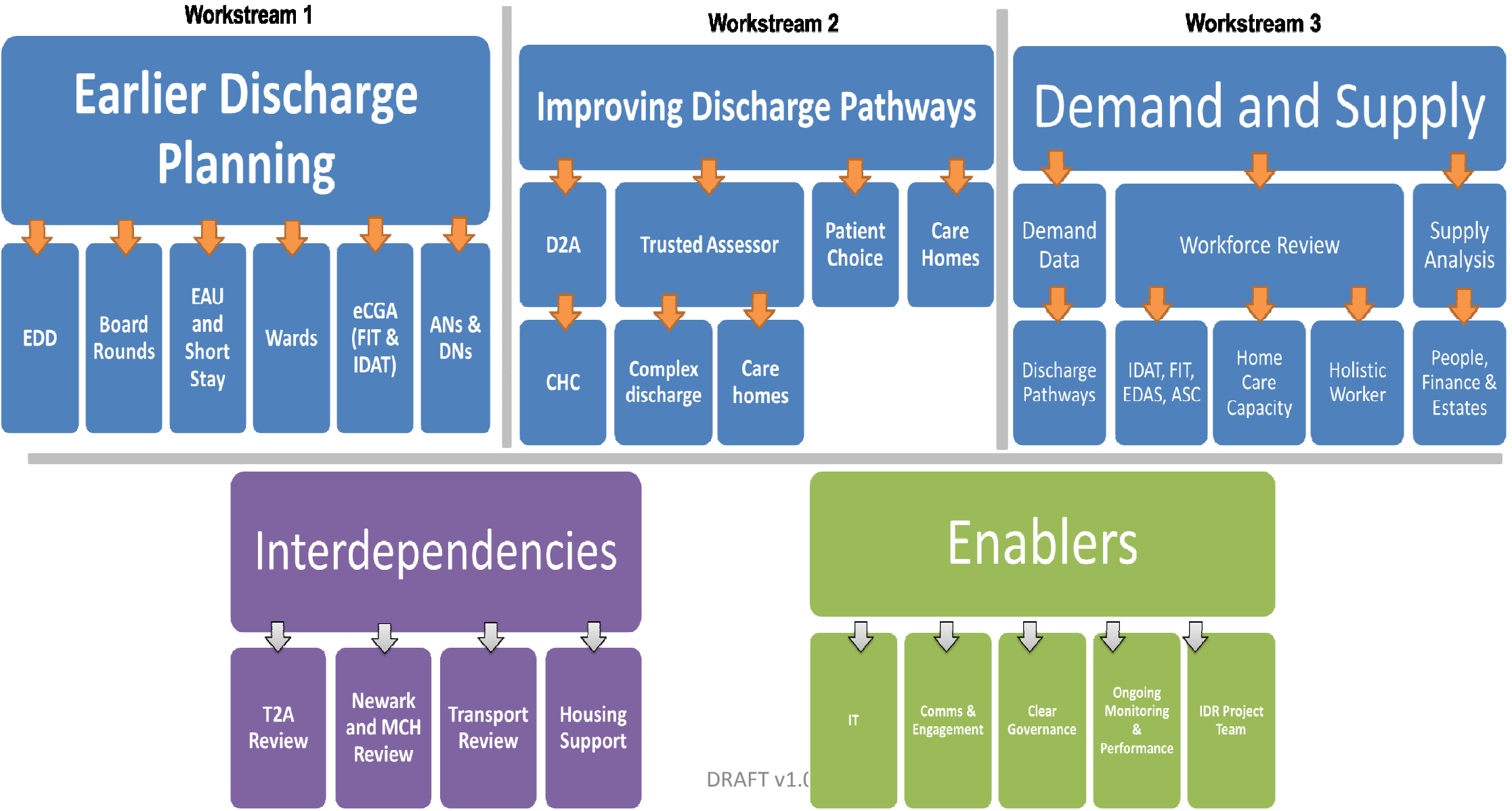

Governance

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