scie social care institute for excellence

in collaboration with Integration and Better Care Fund

# Better Care Fund resources

# Transforming intermediate care (IC) services in Doncaster

## Scheme

### Who?

Doncaster Borough Council

Doncaster and Bassetlaw Hospitals

Rotherham, Doncaster and South Humber Foundation Trust
Doncaster Clinical Commissioning Group

Doncaster Age UK

FCMS Urgent Care service provider

### What

The delivery model will have a single point of access and triage for all intermediate care services. The focus is on a locality-based Home First Service that will maintain the person at home, avoiding unnecessary hospital admission and providing in-reach into

acute specialist and diagnostic services where required.
Facilitating discharge from urgent care, ensuring continuity with existing support networks, linking closely with primary care.

Home First includes an integrated bed base facility linked to neighbourhoods which will be available for people who can't be safely supported at home.

## Why?

Planning for an improved IC service began after Doncaster carried out an intermediate care review. The findings included:

- lots of duplication and some gaps in provision
- most intermediate care services in Doncaster are set up to support people when they leave hospital, with a large percentage of bed-based provision
- there are not enough home-based services that respond quickly at times of crisis to help people maintain their independence in their own environment
- the review found that approximately 50% of over 75-year-olds admitted to hospital could potentially have been supported at home with different IC services
- more bed-based services than other areas
- commissioning and contracting arrangements contribute to complexity and disjointed provision.

People using services and their carers said:

- the service is difficult to navigate
- there is repetition of assessments
- they would like more flexibility in responses offered
- they would prefer support at home rather than in hospital (not all carers agreed with this, although the majority did).

## When?

Phase 1: Review of IC: 2015–early 2016.
Phase 2: Designing a new model for IC: new model agreed in September 2016.
Phase 3: Testing a new model for intermediate care: November 2016– April 2017.
Phase 4: Full implementation: April 2018 to date.

## How?

The trusted assessor's role is to carry out clinical work and to develop and evaluate the service. It includes community physiotherapy and occupational therapy in-reaching.

The role works into the ED and AMU

and with the frailty team. Responsibilities include:

- mobility and transfer assessment
- liaising with all relevant individuals, professionals and family/carers to ensure personal and domestic activities of daily living (ADLs) can be managed.
- following up with the wider community-based therapy team for further home assessment to determine equipment and treatment needs and onward referrals.

It is a seven-day service aiming to assess at home the same day or within 24 hours.

Any adult over 18 whose medical condition can be managed in the community but who has other complex needs which may be a barrier to discharge home may be referred for assessment.

## Challenges

There were a number of challenges to setting up the scheme:

- limited resources – only one Band 7 therapist (job share) was employed and the role includes service development, resulting in clinical hours being part-time
- other established teams were initially unaware of the new role
- many different pilots were undertaken simultaneously, causing confusion for other care teams
- other services and teams had limited capacity to support both acute and community services
- funding for further timely service development and progression was delayed.

## Impact

There has been positive feedback from people who use services, families and professionals. Outcomes include:

- despite the limited resources of the trial, a significant impact on hospital admission avoidance
- majority home same day
- contributed to change of culture in acute setting – focus now on Home First
- closer working between acute and community therapists
- greater understanding of risk acceptance.

## Case study

Lucy, aged 82, was admitted to ED with a suspected cerebrovascular accident (CVA). She was having trouble standing and was leaning to one side.

Lucy's son explained while attending

her medical assessment that her symptoms, although perhaps a bit worse, were the result of a previous CVA. The assessment team found no new symptoms and Lucy was declared medically fit for discharge.

The trusted assessor was called to assess Lucy. She decided that Lucy's care needs had increased and she now needed two people to help her stand up and two people for some care tasks. (She had previously only needed one person for her support needs.) Lucy also needed a rollator frame because she was at risk of losing her balance when walking. The trusted assessor provided a rollator frame and contacted Lucy's care agency to let them know she would need support from two care workers, but the care manager said they would need a social worker to change Lucy's care package. The trusted assessor contacted the hospital social worker who was able to change the package straight away. She also arranged with the urgent therapy team that they would visit Lucy at home the next day (Saturday) to assess her for additional equipment needs. Without the work of the trusted assessor, Lucy would have had to stay in hospital over the weekend.

View all practice examples link 1

**link 1** | https://www.scie.org.uk/integrated-care/better-care/practice-examples