City and Hackney: Discharge Single Point of Access Service (DSPA)

April 2020

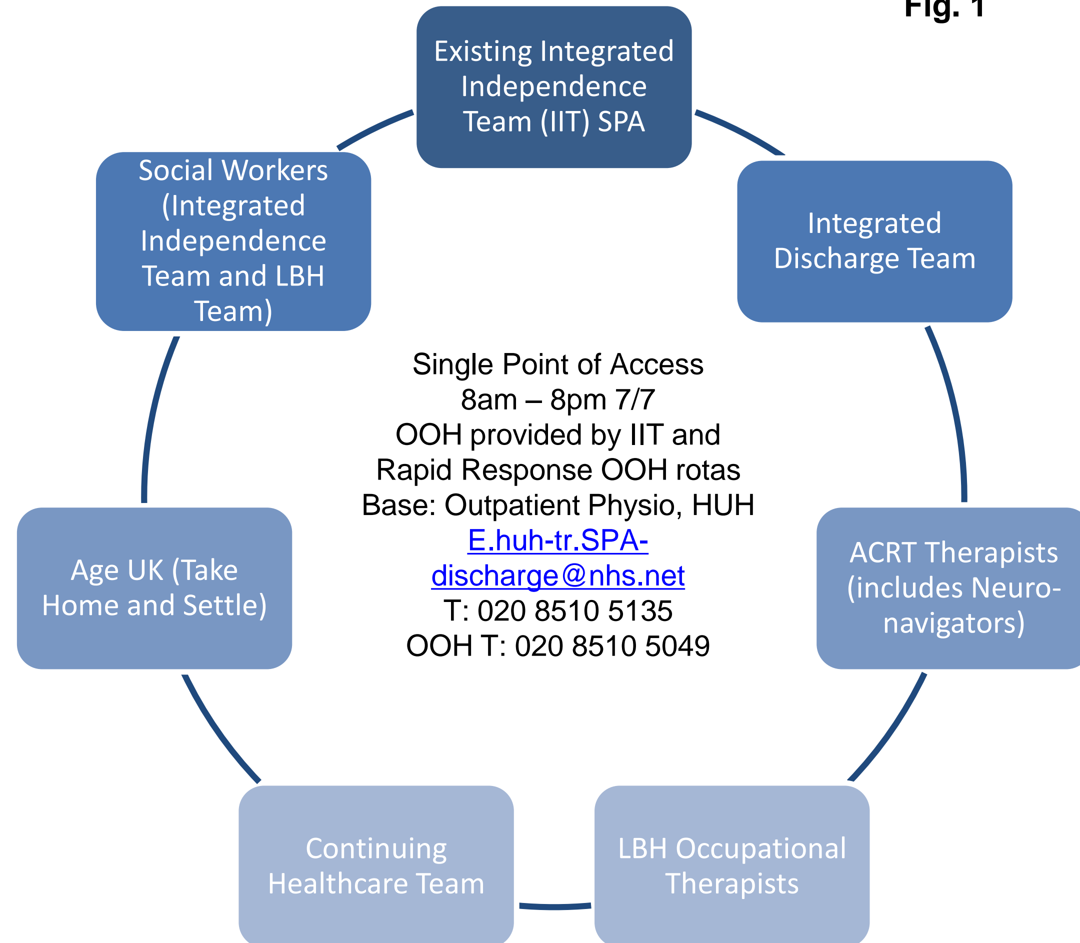
1. Discharge Single Point of Access (DSPA)

The existing Single Point of Access within the Integrated Independence Team (IIT) will be expanded as per fig 1 to enable a dedicated SPA and case coordination function to support same day discharge. The team will benefit from the support from the IIT Rapid Response Team with therapy resource from LBH and the Adult Community Rehabilitation Team (ACRT) reassigned to bolster the Rapid Response Team.

The SPA team will work seamlessly with

- LBH Brokerage Service
- Community therapy provision (LBH Occupational Therapy and HUH ACRT)
- Primary Care
- Wider Voluntary Sector
- Established Neighbourhood Staff, for example Well Being Practitioners
- Hospital porters, hospital transport (including LAS and St Johns Ambulance Service)
- Adult Safeguarding
- Adult Community Nursing

Fig. 1



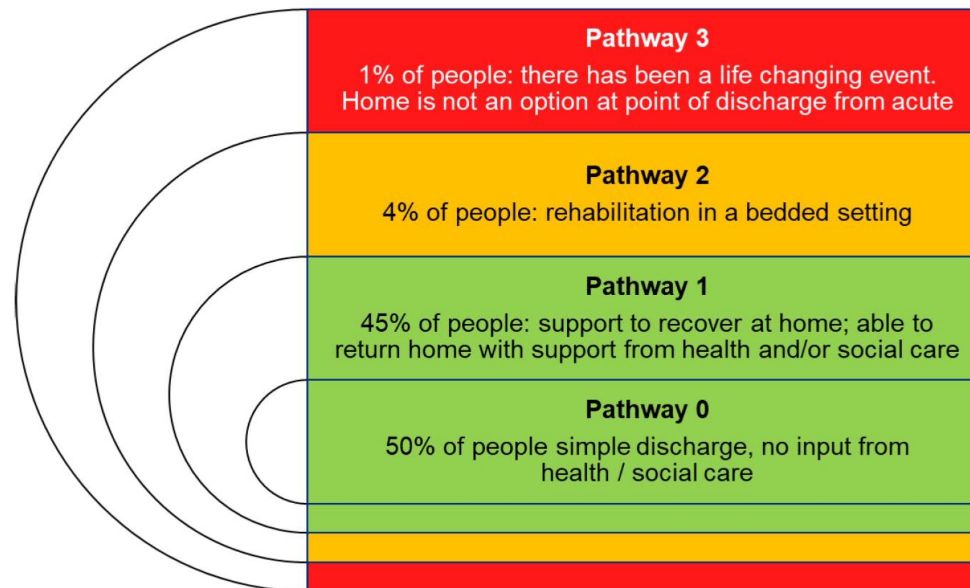
2. Patient criteria and discharge

Fig. 2

There are four clearly defined pathways set out for discharge under this model, the overriding principal is for a Home First approach wherever possible however there will be instances where patients will need to be discharged into interim arrangements so as to meet the agenda of maximising bed and acute hospital staff capacity.

The ward criteria for identifying patients suitable for discharge is simplified to all patients that are medical optimised (clinically safe) for discharge. This applies to all patients regardless of COVID status although the Infection Control Precautions will be adhered to in planning for discharge.*

It is expected that 50% of the patients will not be discharged via the SPA in-reach process and consequently the ward will manage the discharge (Pathway 0) as usual with support from a discharge coordinator.



* https://www.gov.uk/government/publications/covid-19-guidance-for-stepdown-of-infection-control-precautions-within-hospitals-and-discharging-covid-19-patients-from-hospital-to-home-settings/guidance-for-stepdown-of-infection-control-precautions-and-discharging-covid-19-patients

3. Pathways and Referral Process

- The SPA team will in-reach to all acute wards twice daily (Mon-Fri) at 9am (whiteboard) and 2pm. A list of medically optimised patients which are ready for same day discharge will be collated via this process. Weekends will initially be a once per day attendance to each ward via the existing weekend discharge team process with the added availability of the brokerage service. Out of area hospitals will refer direct to the Discharge SPA instead of IIT and ACRT.

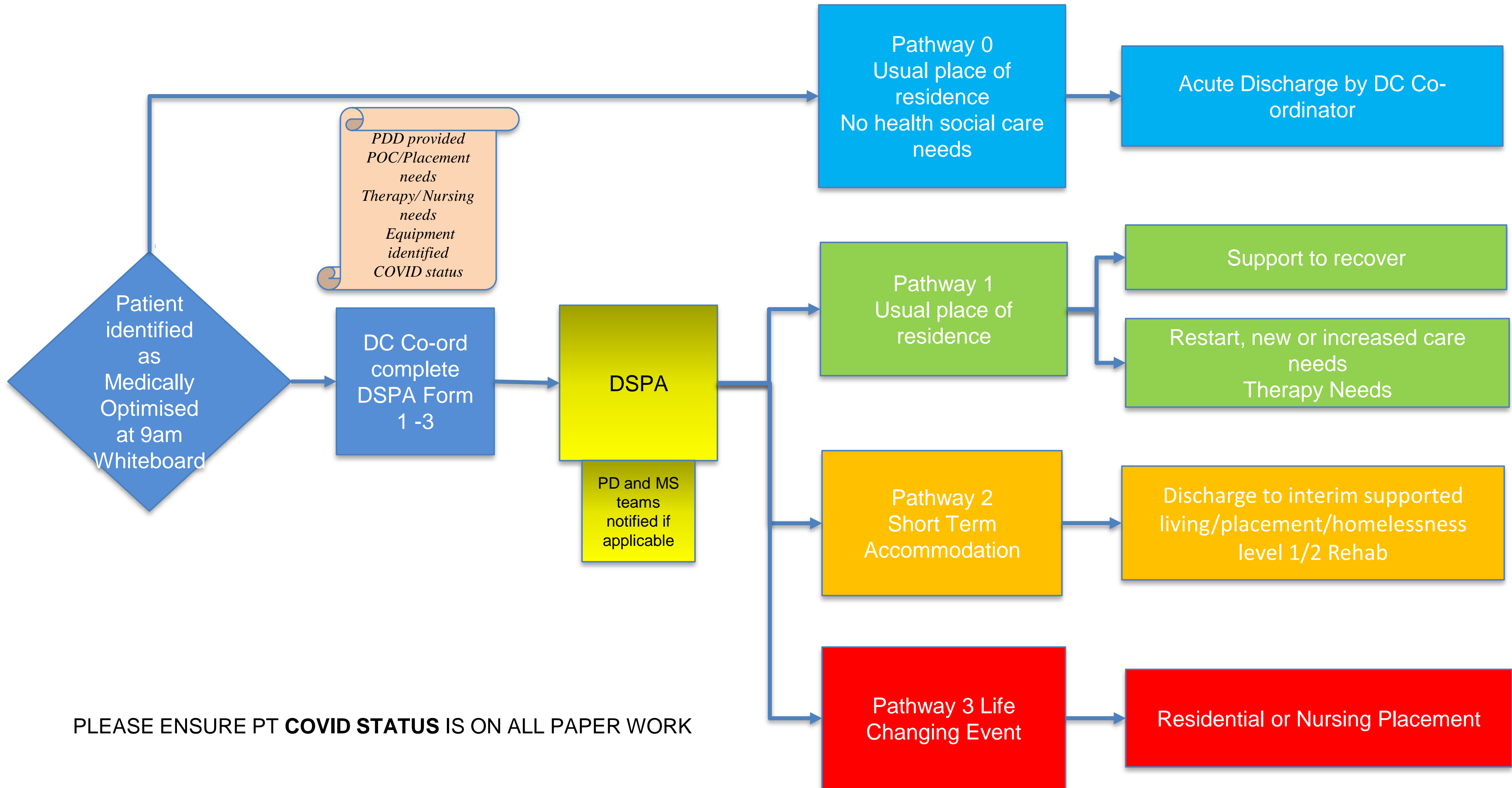
- Usual referrals to other routine services such as Adult Community Nursing will continue by the wards.

- Emergency Department/OMU and ACU continue to refer to IIT Rapid Response as usual.

- Patients in the last days or weeks of life are to be referred directly to the Continuing Health Care Team using the existing Fast Track paperwork who will arrange for rapid discharge to home, care home or hospice. The Hospital Palliative Care Team, where the patient is already known to them can refer directly to hospice.

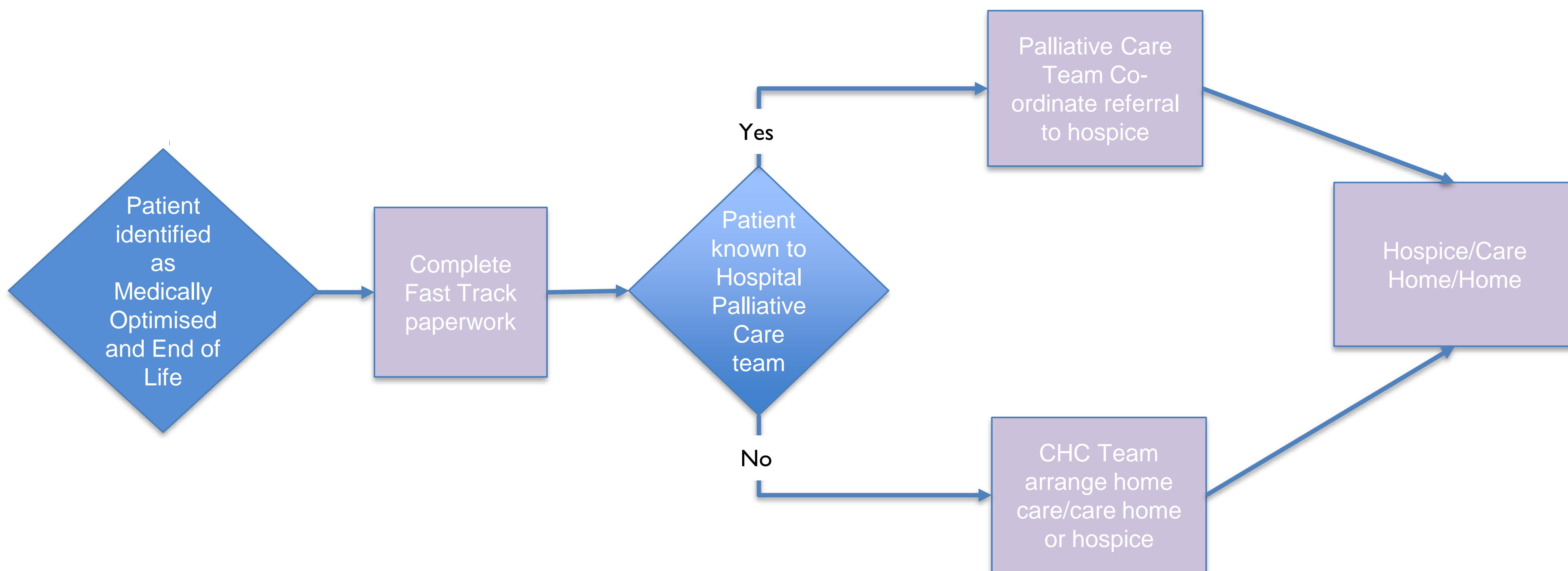
- Duties under the Mental Capacity Act 2005, DOLS and Safeguarding apply during this period and need to be considered/assessed prior to making a decision about discharge

3. Pathways 0-3 Process



3. End of Life Pathway

NHS



PLEASE ENSURE PT **COVID STATUS** IS ON ALL PAPER WORK

4. Summary of Roles and Responsibilities

	Pathway 0	Pathway 1	Pathway 2	Pathway 3	End of Life
Responsible for confirming Medically Optimised and safe for discharge	Acute Ward	Acute Ward	Acute Ward	Acute Ward	Acute Ward
Responsible for Discharge Coordination (apart from Discharge Summary and TTA's which is always the ward role)	Acute Ward + Discharge Coordinator	DSPA	DSPA	DSPA	DSPA
Criteria for Pathway	No input required from Health or Social Care May require input from voluntary provision Provide with ward number	Safe to be left between care calls Requires short or longer term support care package	Requires rehabilitation in a bedded setting (in excess of community provision)	Requires nursing home (care needs in excess of community provision)	In last days or weeks of their life

4. Roles and Responsibilities – Acute Ward

Acute Wards
Have a senior clinical decision maker available to support staff with positive risk taking.
Review patients daily and identity patients for discharge that day at 9am morning whiteboard meetings.
Undertake a second 2pm review of all patients in acute beds to agree who is suitable for discharge that day.
All suitable patients to be added to the discharge list by the SPA team member attending the 9am and 2pm reviews.
Where possible include the COVID-19 test results in documentation.
Duties under the Mental Capacity Act 2005, DOLS and Safeguarding apply during this period and need to be considered/assessed prior to making a decision about discharge.
Discuss decision to discharge with the patient and family and provide the patient with the Discharge Leaflet applicable to the discharge destination.
Refer patients in the last days or weeks of life directly to the Continuing Health Care Team using the existing Fast Track paperwork who will arrange for rapid discharge to home, care home or hospice. The Hospital Palliative Care Team, where the patient is already known to them can refer directly to hospice.
Discharge summaries and TTAs to be completed as usual.
The guidance stipulates that Maintaining good decision making is critical when planning for discharges.

Every patient on every general ward should be reviewed on a twice daily board round to determine the following. If the answer to each question is 'no', actively consider discharge to a less acute setting.

- Requiring ITU or HDU care
- Requiring oxygen therapy/ NIV
- Requiring intravenous fluids
- NEWS2 > 3 (clinical judgement required in patients with AF &/or chronic respiratory disease)
- Diminished level of consciousness where recovery realistic
- Acute functional impairment in excess of home/community care provision
- Last hours of life
- Requiring intravenous medication > b.d. (including analgesia)
- Undergone lower limb surgery within 48hrs
- Undergone thorax-abdominal/pelvic surgery with 72 hrs
- Within 24hrs of an invasive procedure (with attendant risk of acute life threatening deterioration)

4. Roles and Responsibilities – Discharge Single Point of Access (DSPA)

Single Point of Access Team
Facilitate the rapid discharge of patients from hospital within 3 hours of notification of being medically optimised.
Attend the 9am and 2pm ward reviews and ensure all suitable patients are added to the discharge list.
Work jointly with the acute wards in rapidly assessing the needs of the patient to determine what is required to support the discharge, for example equipment, care support or placement (interim, housing with care, nursing home, inpatient rehabilitation) and to refer/liaise with the relevant teams/agencies as required. The care coordinator role will be pivotal in this.
The DSPA Social Worker to complete the immediate service request on MOSAIC so that brokerage can initiate the care agency process.
Identify who is best placed (single professional or MDT) to follow the patient at home either on the day of discharge or the following day to undertake a community based assessment of need and to rapidly arrange for any additional requirements to be put in place. All patients will be provided with a ward contact number on discharge as a safety net and the DPSA will risk assess all patients for urgency of community follow up.
Ensure community based continuation of therapy input and nursing care as identified at assessment. This will be achieved via referral to existing teams and/or redeployment of staff to provide the relevant treatment at home or placement.
Maintain a robust database for all referred patients, and as part of this track patients on pathways 1-3 for follow up and ongoing assessment of long term need once post discharge recovery is complete.

5. Urgent Housing Options Pathway

The guidance covers moving homeless adults, including those discharged from hospital and prison, into emergency temporary accommodation; the categories are:

- People who are symptomatic and need to self-isolate
- People who are asymptomatic with underlying health needs
- People who are asymptomatic with no underlying health needs who are street homeless
- People who are street homeless with complex needs

Routes into the accommodation will be via:

1. **Hospital Discharge Team**

   People being discharged from hospital will be referred into Brokerage who will arrange a bed in the Travel Lodge for an initial assessment of need with a view to identify their ongoing housing options and develop a personalised package of care/support: brokerage.email@hackney.gov.uk 8 a.m. until 8 p.m. 7 days per week.

2. **Hackney Street Outreach Team via Streetlink (rough sleepers only) /Greenhouse**

   The second cohort will be those who are actively homeless: CHAIN verified, non-CHAIN verified and those with No Recourse to Public Funds. Many with low/ medium support needs will be accommodated through the GLA's pan-London homelessness provision, but every effort must be made to accommodate those who are street homeless in Hackney and picked by Hackney Street Outreach Team/Streetlink, especially those with high support needs.

3. **Probation/CRC/Immigration Centre (Home Office)**

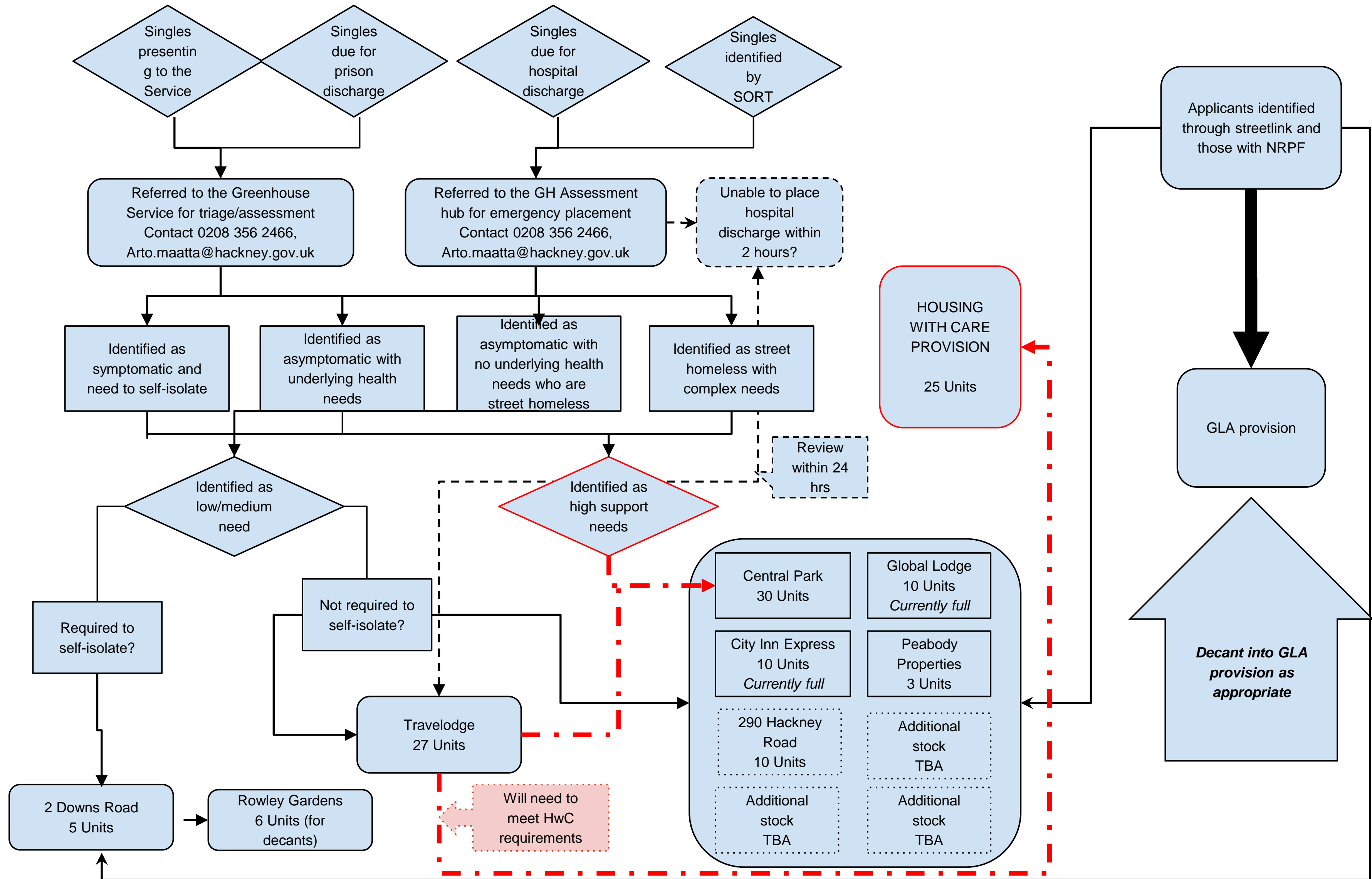
   The third cohort may have been released from prison or an immigration centre.

For cohort 2 and 3, homeless referrals must contact Arto Maatta, Benefits and Housing Needs Team Manager - Singles, 0208 356 2466, Arto.maatta@hackney.gov.uk in the first instance to arrange booking into the Pathway.

All new referrals will access the Pathway via the Assessment Hub at the Travel Lodge; exceptions will be:

- Symptomatic rough sleepers who need to isolate immediately
- Asymptomatic rough sleepers picked up by Hackney SORT or the Streetlink Rapid Response Team who will verify the rough sleeping status of the individual and place them based on the immediate need for vulnerable, street-homeless individuals to self-isolate, and to mitigate the additional workload involved in moving people between setting

5. Urgent Housing Options pathway



5. Contact Details

Osian Powell (HUH Divisional Operations Director) Osian.powell1@nhs.net
SRO

Mervyn Freeze
Head of IIT and Adult Community Nursing
m.freeze@nhs.net

Simon Galczynski (Adult Social Care LBH)
Simon.galczynski@hackney.gov.uk

Nina Griffith (Unplanned Care Workstream Director) nina.griffith@nhs.net

Simon Cole
Head of Integrated Discharge Service
Simon.cole5@nhs.net

Chris Pelham (City of London)
Chris.Pelham@cityoflondon.gov.uk

Arto Maatta, Benefits and Housing Needs Team Manager
0208 356 2466
Arto.maatta@hackney.gov.uk

6. NEL Discharge Hubs

	Tower Hamlets	City & Hackney	Newham	Waltham Forest	Redbridge	Barking & Dagenham	Havering
Catchment area	London Borough of Tower Hamlets resident	London Borough of Hackney resident or Corporation of London resident	London Borough of Newham resident	London Borough of Waltham Forest resident	London Borough of Redbridge resident	London Borough of Barking and Dagenham resident	London Borough of Havering resident
Hospital Supported	Royal London Hospital and St Barts	Homerton University Hospital	Newham University Hospital	Whipps Cross University Hospital	Whipps Cross University Hospital and BHRUT	Barking, Havering and Redbridge University Trust	
Central Telephone Number	07741703940 or 07388998676	020 8510 5135 (Mon to Fri 8am-8pm) 020 8510 7750 (Mon to Fri 8pm-8pm, Weekends & bank holidays 10am – 6pm)	0207 363 8147	07590 806158	0300 300 1743		
Email Contact	elft.thintegrateddischargehub@nhs.net	**huh-tr.SPA-Discharge@nhs.net**	elft.newhamidh@nhs.net	nem-tr.shdt@nhs.net	Hospitaldischargeservice@nelft.nhs.uk		
Hours of operation	8am to 8pm, 7 Days a week						

Homerton Discharge SPA contact details and referral form have been shared with other Hubs to enable discharge back to City and Hackney.
Discharge Hubs have been notified to contact adultsduty@cityoflondon.gov.uk for City of London residents.