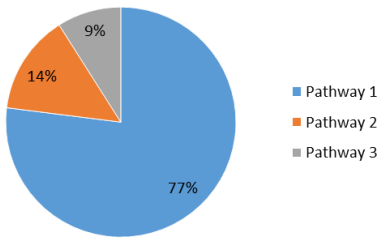
Single Point of Access (SPA)

Description/Background

A SPA was established in April 2020 bringing together One Bromley partners to provide a single point of access to all community discharge pathways, in line with national legislation. The SPA provides acute to community, clinician to clinician hand over with immediate access to community therapies/rehab and nursing provision, as well as domiciliary care or placement, to safely discharge patients. All patients going home are seen within 24 hours of discharge by a therapist to establish the most appropriate community pathway, with assessment of long term care and support needs taking place in the community following a period of recovery.

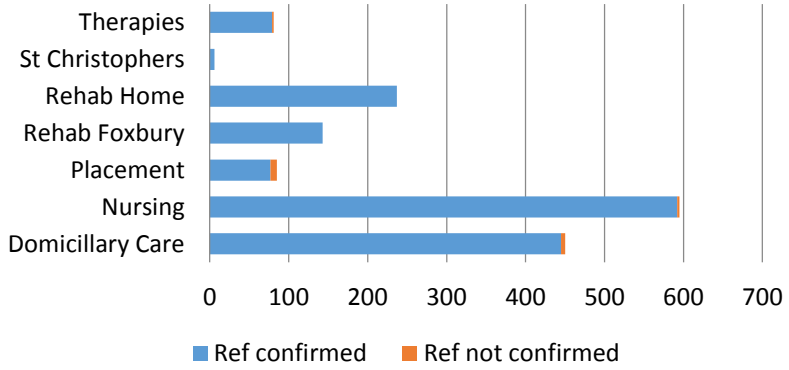
% of patents per pathway



4459 saved bed days in 3 months

75.5% of discharges within 24 hours

257 Welfare Calls in the period



Data as at 220620 from BHC online Qliksense system

Objectives

- Implement an integrated model to provide a single pathway to manage all supported hospital discharges as per the Hospital Discharge Guidance
- Meet requirements in the Adult social Care action plan
- Sustain the Hospital Discharge Service, working across secondary care and community providers in partnership with social care. Includes daily reviews of all patients in a hospital bed on the Hospital Discharge List; prompt and safe discharges when clinically fit and in line with infection control requirements with the planning of ongoing care needs arranged in people's own homes; and making full use of available hospice care.
- Provide wrap around care and support at the point of discharge with patients moved onto the most appropriate pathway following a period of recovery to ensure maximum independence and recovery.
- Gather feedback from patients receiving supported hospital discharge to ensure their views are fed into any improvements or refinements to the service.

Outcomes & Benefits

1	1839 discharges through the SPA to date: 854 from the PRUH, 75.5% within 1 day
2	3047 number of patients managed in the community via the CMS
3	PRUH has remained top 3 performing hospitals in London throughout Covid19 with no delayed transfers of care in the period
4	Improved quality of discharge due to clinician to clinician hand over and agreeing discharge plan and requirements for safe transfer
5	4459 saved bed days from the PRUH in 3 month period
6	Increased access to rehab services (outcome of clinician to clinician hand over and welfare check) increasing level of independence of patients/clients
7	Decreased from 1st to 6th in LAS call outs to care homes in London (April 19 vs April 20). However non-conveyance rate has increased from 24% to 38%

Single Point of Access (SPA) - Discussion

Lessons Learnt

- Strong foundations building on the BHC CCC infrastructure to develop the 'SPA'
- Single clinician to clinician phone call to refer to ALL community services has streamlined discharge pathways, reducing confusion and delivering needs led care
- Community MDT approach to meet presenting needs moving away from discreet pathways and allowing fluid movement between pathways
- Agreeing discharge at point of referral for some pathways – improving quality and timeliness
- More effective market management with health and social care POC and placements managed together
- Immediate access to care and support to allow assessment of interim and long term support to happen post discharge
- Achieved parity of esteem between mental and physical health
- Welfare Calls provide significant system benefits including improving quality of discharge and maximising independence
- System enabled by single budget to fund discharge

What does the service look like over the next 6 months / 1 year

The benefits of the SPA have been felt across all organisations in the system and for patients themselves
Within the next 6 months

- Funding of immediate POC and placements will be defined – currently 100% funded by Covid19 Health funding and a key success factor
- Pre-Covid 19 resource will be redeployed into a permanent structure with gaps in the system addressed
- Feedback from patients using supported discharge will be assessed to see if any improvements or refinements need to be made
- Care Managers are co-located within the SPA to better enable discharges into social care

How does the model respond to Escalation in COVID patients/tackle inequalities / other etc..

Management of all hospital discharge including Covid19+ patients. Those that are shielded or vulnerable to Covid19