Single Point of Access (SPA) and Discharge Update

Health Scrutiny Sub Committee

14th January 2021

Context

On the 19th March 2020 the government published its 'Covid-19 Hospital Discharge Service Requirements' which stated unless required to be in hospital, patients must not remain in an NHS bed. The guidance required acute trusts and community health and social care providers to work together to deliver a discharge to assess model that facilitates immediate discharge from hospital with assessment of need taking place in the community.

Guidance outlined four discharge pathways with pathway 0, where patients were discharged home with no further support, being managed by the Trust and pathways 1-3, discharge required further support in the community, being accessed via a Single Point of Access (SPA) for community health and social care services.

The single point of access was required to:

- Function seven days a week 8am-8pm
- Provide a single route for all community health and social care services
- Accept assessments from hospital staff on the needs of individuals
- Use multidisciplinary teams on the day of discharge to assess and range packages of support
- Provide timely access to equipment
- Maintain the flow of patients through the pathway ensuring assessment of long term care and support needs are undertaken following a period of recovery

In Bromley the local system pulled together to build on the existing strong foundations including the Bromley Health Care (BHC) Care Coordination Centre; the Local Authority Discharge to Assess model; the Transfer of Care Bureau (T0CB) and a system of strong working relationships to deliver a comprehensive and robust model.

Whole system approach

Partners from across the system have collaborated resources to form a SPA and work as a virtual Multi-Disciplinary Team (MDT) simplifying the hospital discharge process.

Therapy, nursing, administration and management support from Bromley Healthcare; therapy, administration and management support from Kings Transfer of Care Bureau and therapy and care management support from LBB have been brough together to form the 8am-8pm 7 day a week SPA.

Funds from Winter Transformation and NHS Covid monies have provided extra capacity as required.

Care managers from St Christopher's and Oxleas are active members of the SPA MDT, supporting to manage clients in their transition back to the community.

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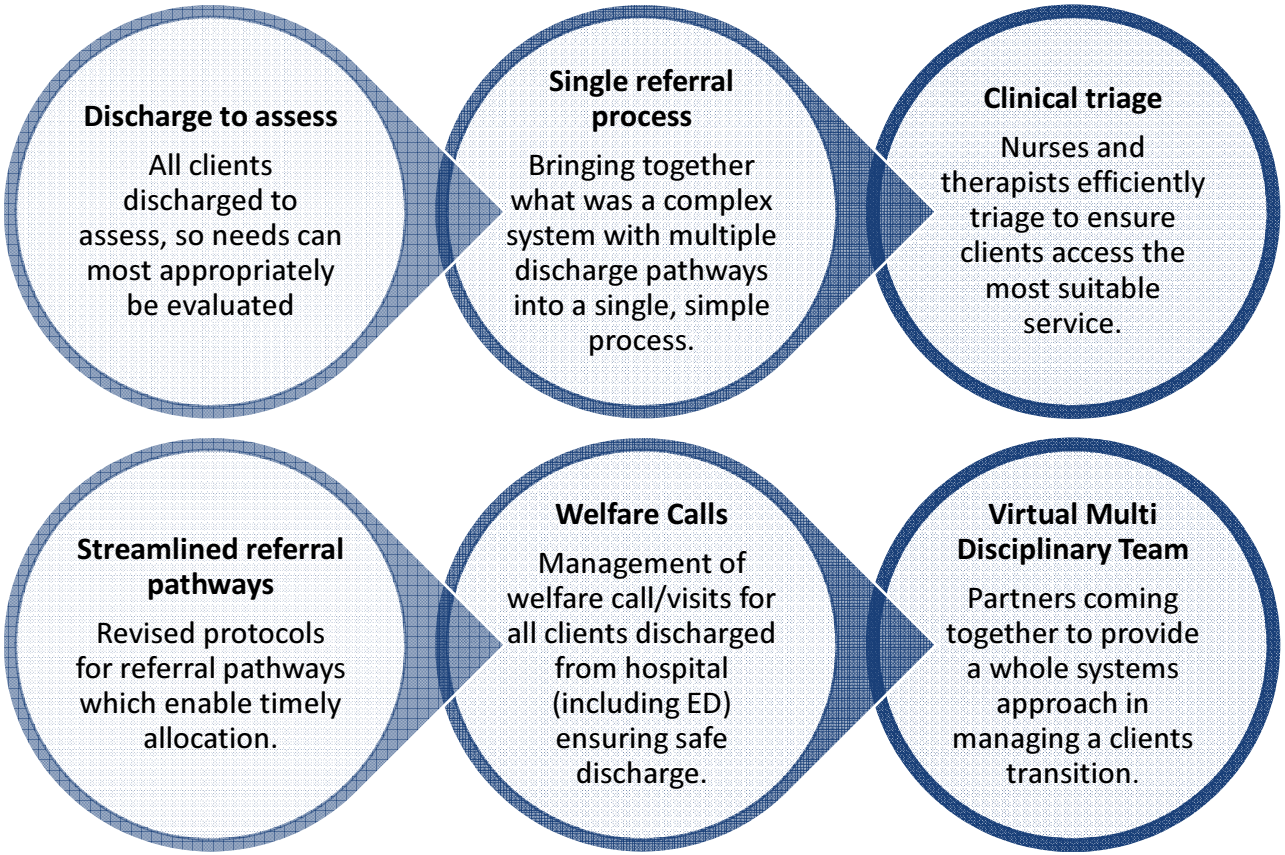
The redesigned model

Key features of the SPA model:



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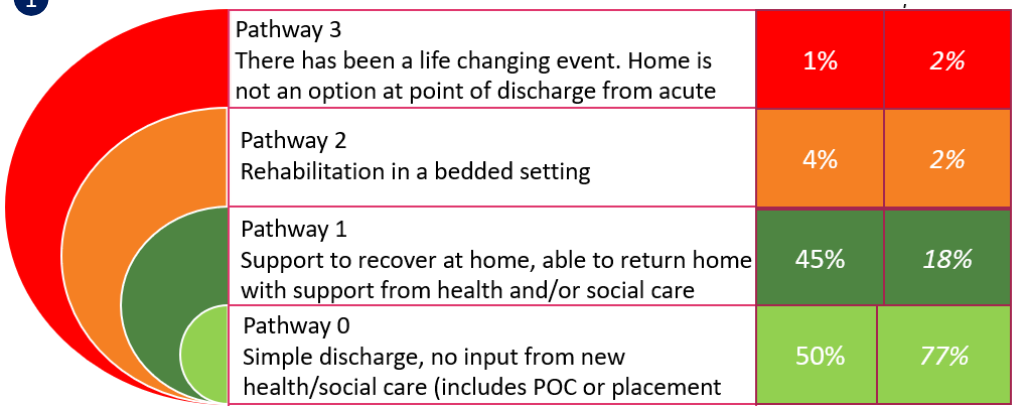
Activity March – December 2020

(source Bromley Community Health)

1



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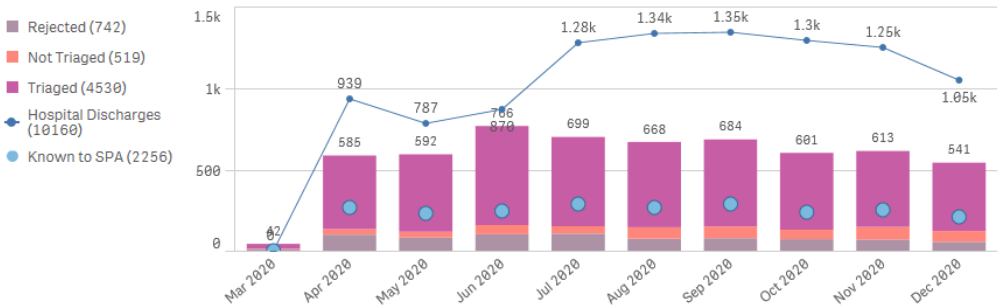

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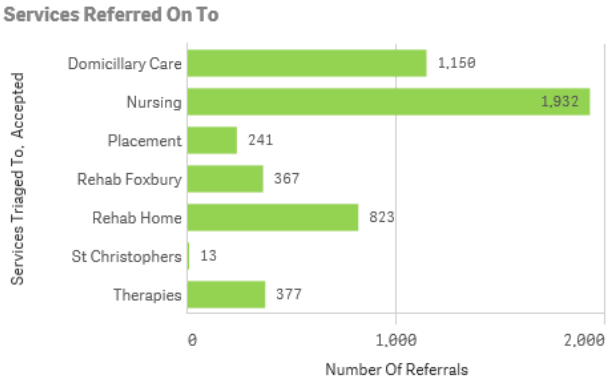

The SPA is effectively triaging high volumes of referrals with many clients requiring multiple referrals.

- On average, the SPA is processing **576 referrals a month** accounting for approx.
- On average **50% of hospital discharge** are supported through the SPA
- Hospital discharge outcomes show than **18%** of clients are being **supported at home**.
- On average, pathway 1 clients need **2 onward referrals**

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Benefits

More timely and client focused

A single referral process supported by streamlined pathways and effective clinical triage ensures that the time and effort it takes to make a referral is minimised. By taking a whole systems approach to a client referral and evaluating needs within a community settings we can ensure services are tailored effectively.

Greater flexibility with resources

By managing a client's access to services within a single access point, resources can be used flexibly, preventing delays or gaps from arising and thus achieving timely discharge and effective support for people in their own homes/prevent admission.

More responsive to changing needs

The SPA has facilitated a professional network across all discharge pathways which allows for a reactive approach to post-discharge changes/issues (this has been essential within the current context where clients needs can be unpredictable).

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