Hillingdon Integrated Discharge Hub

Standard Operating Procedure

1.0 Introduction & Background

This document sets out the standard operating procedure (SOP) that health and social care partners will work within to operate an Integrated Discharge Team (IDT) and align to deliver to the national discharge policy, but ultimately, the aim is to improve the discharge experience for patients coming out The Hillingdon Hospital Site and the Hillingdon rehabilitation and stepdown beds.

Hospital discharge and community support: policy and operating model - GOV.UK (www.gov.uk)

Operating as an integrated team this SOP details the structure, function and the roles and responsibilities of the hub. This process will be jointly agreed by The Hillingdon Hospital, The London Borough of Hillingdon, Central North West London Community Health Trust and NWL CCG.

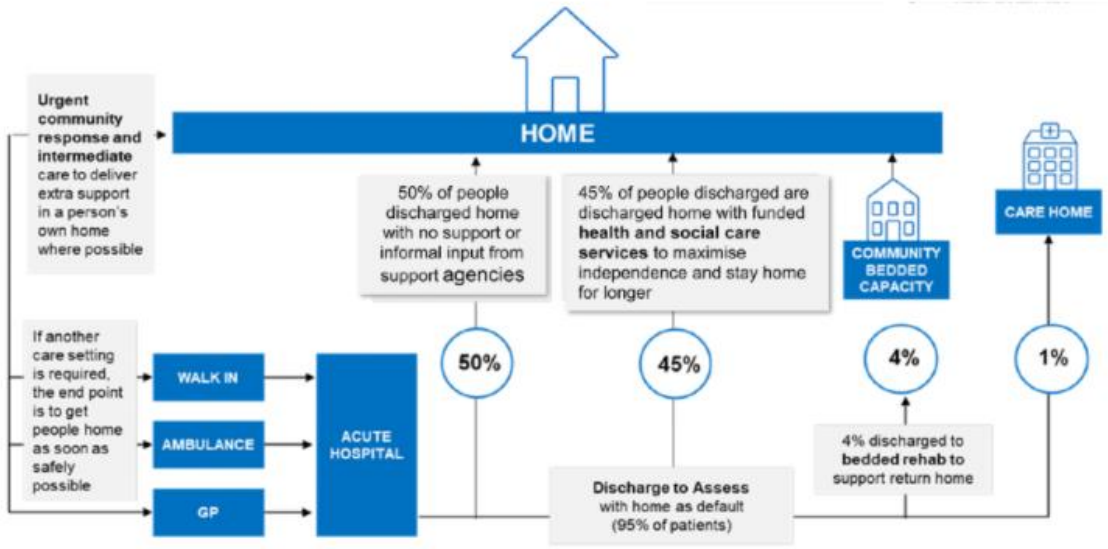


Figure 1 Discharge to assess process (Discharge Planning and Community Support Policy and Operating Model August 2020)

1.1 Overarching principles of the Hub

Single integrated Hub with an established multidisciplinary workforce who use effective channels of communication and escalation that are responsive to the fluctuating demands, whilst contributing to a positive culture with strong governance. Hub ethos is a Home First approach which expects people to return home as the preferred option, rather than end up by default in bed-based care. Discharge to Assess (D2A) enables this approach through a single point of access building on the successful joint working developed during the COVID period. The hub has a planned and responsive approach to discharge, aiming for patients not to be

in hospital any longer than they need to be and providing support based on individual needs to ensure safe discharges. A hospital is not the right environment for people to make long-term decisions about their ongoing care and support needs. Home First and Discharge to Assess enable assessments to be completed at home with families, carers or advocates.

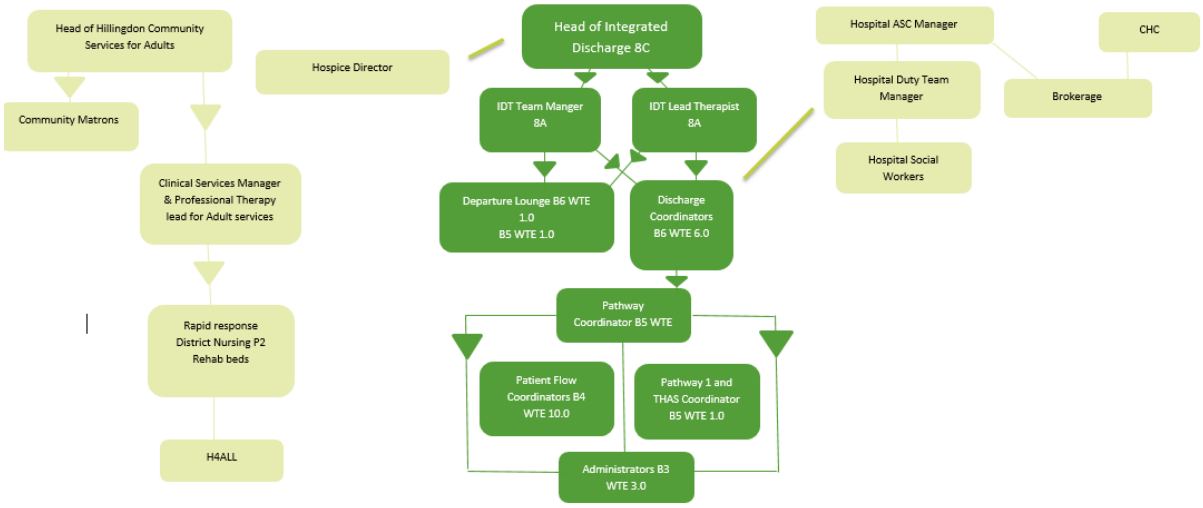
1.2 Objectives of the Hub

Hillingdon Discharge Hub is one branding, one vision to enable patient discharges on a home first model using a strength-based approach. This helps people maintain their independence and maximise their health and wellbeing, which also supports admission avoidance. This set up and process has been jointly defined by all partners of the Hillingdon Healthcare Partnership (HHCP).

1.3 People who may benefit from the Integrated Discharge Hub approach

All patients who are to be discharged from Hillingdon hospital or Hillingdon stepdown beds. This includes people with complex health and/or care needs, including people classed as self-funders and patients who are from out of the borough.

1.4 Structure



1.4 Hub Roles, Key Responsibility Areas, Partner support, Working Arrangements

Head of Integrated Discharge

- Monitoring of flow across THH/Stepdown beds/Community resources
- Supporting the utilisation and flexibility of services to meet patient needs
- Point of escalation for both internal and external teams
- NWL link
- Lead for LLOS reviews
- Analyse trends in discharges & adapt accordingly

Discharge Team Manager 8a

- Daily management of IDT and working rhythm
- Attends daily safeguarding update meeting
- Complex case management
- Drives home first ethos across trust
- Escalation
- Education across trust

Lead Therapist Discharge Team 8a (1 year Trial post)

- Support weekly LLOS reviews
- Management of P2 rehab and stepdown beds
- Support IDT manager in staff management
- Complex case management
- Drives home first ethos across trust
- Escalation
- Education across trust

Duty ASC Team Manager (remote working)

- Support triage of P1 and P3 referrals
- Allocation/confirmation of new POC
- Allocation/Confirmation of increases of POC
- Allocation/confirmation of new P3
- Allocation/Confirmation of increases of P3
- Virtual Mental Capacity Assessments
- Resource and support
- S42s
- Input into escalation events MADE/ Perfect Week

Rapid response coordinator (remote working)

- Support triage of P1 referrals
- Allocation of daily therapy slots
- Link to Night sitters/Day sitters
- Support to bridge District nurse input

Discharge Co-ordinator Nurse Band 6 x 6

- Duty role x1 per day managing P1 D2a flow
- Completion of COVID 19 D2A forms
- Drive Home first ethos with wards
- Complex case management
- Liaising with family
- Trusted information provider to facilitate assessments from Care Homes and stepdown beds
- *All Band 6 nursing staff have completed CHC training to support completion of NWL D2A forms*

Senior Pathway facilitator Band 5 non clinical

- Management of patient flow from THH to P2 rehab/step down beds
- Co-ordination of P3 patient discharges
- Supporting Palliative patient discharges

Patient flow coordinators (PFC) Band 4 x 10 (rotate wards every 3months)

- Ward based
- P0/P1 discharge support
- Live system reporting
- Ward based problem solving
- P2 patient identification
- Suggestions/escalations for the ward discharge planning
- Identification of patients suitable for THAS

Pathway 1 and Age UK Take Home and Settle coordinator Band 4

- Daily administrative coordination at THH of Pathway 1 and THS referrals
- Attendance at daily triage calls
- Allocation of Age UK support workers to:
  - ❖ Escort patients home
  - ❖ Collect shopping
  - ❖ Collecting TTAs
  - ❖ Provision of taxi for appropriate patients and provide escort in taxi home.

Admin Band 3 x 3

- Monitor inbox
- Telephone calls
- Support IDT Nurse coordinator in office
- Data reporting
- Cover Take Home and settle coordinator out of hours and weekends
- Updating P2 tracker internal and external beds.

1.5 Operational Process of Hillingdon Hub

IDT Daily Huddle 08:00/15:30
IDT Manager/Lead Therapist
Discharge Co-ordinators
Pathway facilitator
Head of Integrated Discharge when available

Site meeting 08:30/12:00/15:00/16:45 (7 days per week)
IDT duty nurse
IDT Manager or Head of Integrated Discharge

Medical Handback/Discharge meeting Weekends only 09:00
IDT Discharge Co-ordinator
Senior HHCP representative on duty
Trust senior therapist on duty

Daily triage calls 09:00/11:00/13:30 (7 days per week)
IDT Nurse
Rapid response coordinator
Duty Adult Social Care Team manager (week days only)
Comfort care agency coordinator (weekends only)

Daily THH discharge escalation calls (10:00/14:00)
IDT Manager
IDT Lead Therapist
Lead CSP
Head of Discharge (black internal incident)
Head of Site (black/internal incident)
PFCs
IDT Duty Nurse
Departure Lounge Nurse
Ward Managers
Link Managers (black/internal incident)
Internal services

Daily HHCP calls 09:30 & 16:30 (Monday -Saturday)
Combination of:
Managing Director HHCP
Director for Hillingdon and Mental Health Services
Associate Director of Outer London Services
Hillingdon Borough Lead (NWL CCG)
Head of Integrated Discharge
IDT Manager
Clinical Service Manager & Professional Therapy Lead for Adult Services – Hillingdon
Head of Hillingdon Community Services for Adults
Head of Site - THH
Brokerage
H4ALL
Palliative Nurse Lead
Hospice Director
CHC representative
Duty Adult Social Care Team manager
THH representative
Flexibility to increase number of meetings per day dependant on Hospital pressure/number barriers to discharge

LLOS ward based weekly reviews
Head of Integrated Discharge
Head of Site
THH Head of Therapy Services
Lead Clinician

LLOS Case management office based reviews (2 x per week)
IDT Manager/Lead Therapist
Discharge Nurses
Head of Integrated Discharge when available

NWL sector calls
Head of Integrated Discharge (Hub and IDT/P2 bed representative)

1.6 Principles and Approach for unblocking discharge delays
Morning daily escalations calls to discuss all medically optimised patients, complex patients, palliative patients for discharge, Hospice bed capacity, D2A capacity same day/next day therapy availability, P2 rehab and stepdown bed availability and any other concerns.
Afternoon daily escalation calls reviewing of the medically optimised patients, actions from morning meeting and further escalations support as required.

1.6.1 Weekend arrangements
Escalation calls continue on Saturdays to ensure executive support and clear escalation. A Senior Manager to be on site Saturday mornings to support the hub escalations, role model and unblock delays to discharge. Triage calls continue as normal with exception to change in attendance (refer to section 1.5 above).

<u>During winter surge this may be extended to 7 days to include Sundays</u>

1.7 Governance arrangements
Hillingdon Discharge Hub are following the National Discharge policy. Agreed escalation process and pathways are in place for escalation and access to Hillingdon services. Hillingdon has developed and internal Dashboard for capturing incidents and complaints. Head of IDT creates a link between HHCP to facilitate visibility of complaints and incidents and support shared learning.

1.8 Key performance indicators/ success measures
Percentage of discharges by Pathway
LLOS 7-13 days, 14-20 days, 21 days +
D2A capacity use
Number of discharges before Midday

1.9 Terms of reference for Discharge Hub huddles and schedule
Membership
As per section 1.5 above

Chair
HHCP escalation call Chair is required to ensure clear actions are identified for all MO patients and that capacity for all services is shared and any concerns are raised.

Frequency
As per section 1.5 above.

2.0 Appendices
NWL D2A referral form
THH right time right care policy
~~LOS SOP (in development)~~