Humber Teaching
NHS Foundation Trust

STANDARD OPERATING PROCEDURE COMMUNITY - POCKLINGTON HUB BEDS AND INTERMEDIATE CARE

Document Reference	SOP23-018
Version Number	1.0
Author/Lead **Job Title**	Fiona Holland (Advanced OT) Katie Barraball (Therapy Lead) Rachel Laud (Clinical Lead UCR / Therapy)
Instigated by: **Date Instigated:**	Matthew Handley – Community & Primary Care General Manager Kerry Brown – Clinical Lead
Date Last Reviewed:	18 May 2023
Date of Next Review:	May 2026
Consultation:	Community Services Clinical Network Group
Ratified and Quality Checked by: **Date Ratified:**	Community Services Clinical Network Group 18 May 2023
Name of Trust Strategy / Policy / Guidelines this SOP refers to:	Community - Hospital Discharge Service SOP22-032.pdf (humber.nhs.uk)

VALIDITY – All local SOPS should be accessed via the Trust intranet

CHANGE RECORD

Version	Date	Change details
1.0	*May 2023*	*New SOP. Approved at Community Services Clinical Network Group (18 May 2023).*

Contents

1. INTRODUCTION

The overarching aim of both intermediate care and Pocklington Hub beds is to prevent hospital admission and facilitate timely discharge.

- To provide ongoing assessment to determine future care and support needs.
- To provide support during a period of ill-health to maximise level of independence and/or return to previous level of independence where possible.
- To gain confidence with mobility and all self-care tasks by having access to therapeutic interventions.
- Provide access to services to maximise independent living, e.g., assisted technology and signposting to relevant agencies.
- Health and social care professionals to work in partnership with carers and family to give the confidence to offer appropriate levels of support to aid independent living.
- Any health conditions can be treated and improved through access to appropriate nursing intervention and medical care and review, which complements re-enablement and is appropriate to the hub environment.
- To care for people closer to home.

2. SCOPE

This standard operating procedure (SOP) outlines the role and responsibilities of the staff within Pocklington community team and the Hospital discharge team (HDS), East Riding Yorkshire Council, Wold Haven Residential and Pocklington Group Practice.

It outlines its key functions and the procedure for patient flow into the HUB beds and intermediate care in Pocklington Locality. Within Pocklington Locality there are several pathways to access differing services and this SOP aims to align the process for each and provide a clear pathway for referral and triage.

The aim of utilising a senior triaging clinician within HDS at the point of referral is to free up the capacity of clinicians who are dealing directly with patients within community services and support patient flow from the Acute partners. The HDS will co-ordinate and manage the flow of patients from community and acute bedded units on pathways 1, 2 and 3 and liaise directly with acute partners daily.

3. DUTIES AND RESPONSIBILITIES

Locality Matrons / NHS Service Managers

- Will provide clinical support and route of escalation.
- Will escalate to the Clinical lead / general manager of community services concerns related to the safe and effective running of the services.
- Will work with the divisional clinical leads; team Leads, unit managers, medics, and nursing staff to ensure effective communication to ensure staff and patient safety.

Hospital Discharge Service Team

- Will provide a single point of contact.
- Will provide a telephone triage service to for all referrals into Wold Haven Residential HUB beds and intermediate care from acute partners including step up patients from the community.
- The HDS clinician will review all patients referred into the service and will allocate to the appropriate clinical team.
- The service operates 08.00 – 18.00 6 days a week (Sundays excluded).

Pocklington Community Team

- Will provide a designated co-ordinator for intermediate care / UCR 5 days a week 08.00 – 16.00. (weekends excluded).
- Will familiarise themselves with the SOP and escalate any concerns / training needs to their line manager.
- Will understand the role of the HDS service in triage and allocation of referrals

Wold Haven Residential Staff

- Will provide a daily sit rep to HDS service hnf-tr.hospitaldischargeservice@nhs.net detailing occupied beds and beds available for admission. Template in appendix 1.
- Will familiarise themselves with the processes within this SOP and linked procedures within the East Riding of Yorkshire Council.
- Will ensure all admissions, stays and discharges are dealt with in line Wold Haven Residential procedures and comply with CQC registration.
- Residents should be admitted before 18.00. Only by exception and agreement should admissions be after 18.00. However, the person **must** arrive at the Wold Haven Residential site by 19.30.

4. PROCESS

4.1. Discharge Pathways

Step down from Acute and Community Hospital settings

Discharge to assess model – pathways

Pathway 0
50% of people – simple discharge, no formal input from health or social care needed once home.

Pathway 1
45% of people – support to recover at home; able to return home with support from health and/or social care.

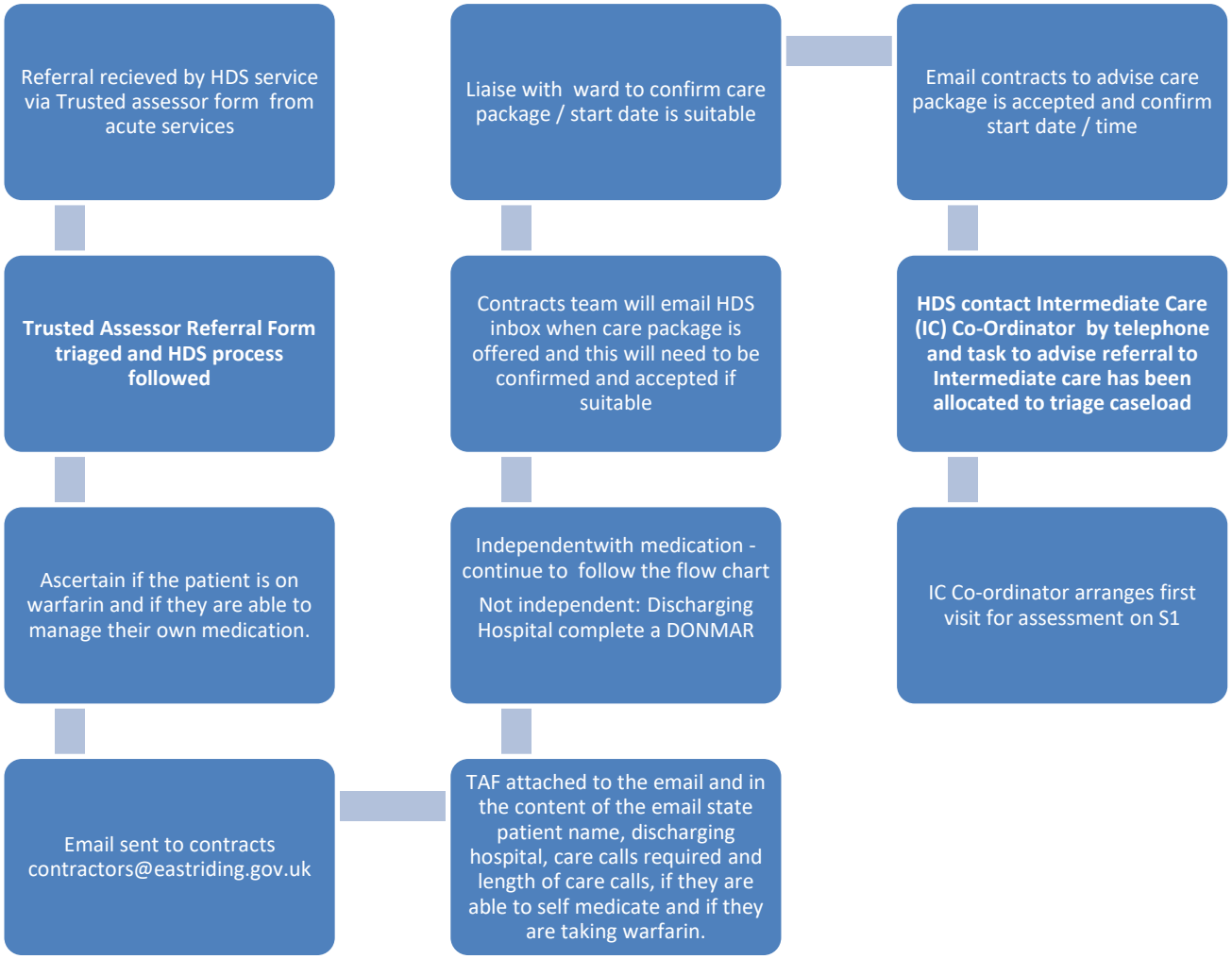
Pathway 2
4% of people –. recovery, rehabilitation, assessment, care planning or short-term intensive support in a 24-hour bed-based setting, ideally before returning home

Pathway 3
1% of people – require ongoing 24-hour nursing care, often in a bedded setting. Long-term care is likely to be required for these individuals.

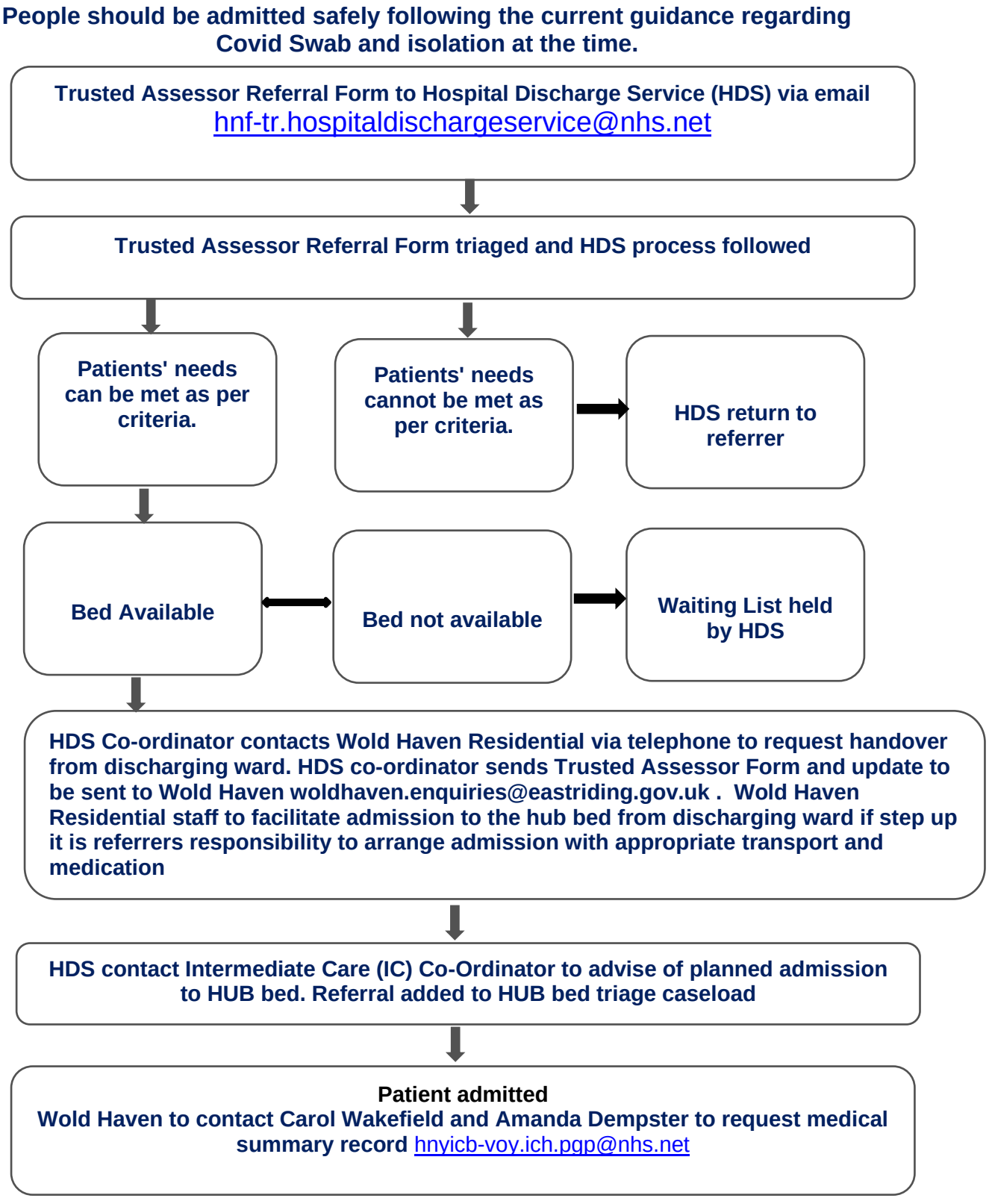
The discharge to assess pathways 1-3 will only be successful if NHS organisations work hand in glove with adult social care colleagues, the care sector, and the voluntary sector. The HDS Team will co-ordinate and manage the discharge arrangements for all patients from community and acute bedded units on pathways 1, 2 and 3 into HTFT services where appropriate.

4.2. Intermediate Care Referrals

Email address - contractors@eastriding.gov.uk



4.3. HUB bed Referrals (step up and step-down referrals)



Admission Criteria for Wold Haven Residential HUB beds

- Age 65 and over.
- A patient of the Pocklington Group Practice.
- Medically stable – screening tool (TAF) and News Score to be used by health staff.
- Have potential to improve medical status following a health crisis which has affected their independence, but do not require 24-hour nursing care.
- Ability to engage in rehabilitation.
- Admission will prevent hospital admissions or facilitate timely discharge where condition is medically stable and does not require care in an acute setting.
- Patients / Service Users must be able to consent to the care at Wold Haven Residential.
- The patient must bring one week's medication with them, any prescriptions during stay must have the patients home address.
- Require a time limited period to improve daily living skills and determine future levels of support, which will be reviewed weekly at MDT meeting. Admissions to a Hub bed does not give automatic or priority admission as a permanent resident.

Individuals who are in the following categories will be considered, but on an individual basis:

- Patients who have temporary confusion / delirium due to a medical problem, resulting in an incapacity to make decisions about care and support.
- Short term / medically stated non-weight bearing to be assessed on an individual basis.
- Mild memory impairment.
- Where nursing support may be required overnight.

Exclusion Criteria for Wold Haven Residential HUB beds

The following patient groups are **not suitable for** community services and therefore referrals will be rejected **unless there are exceptional circumstances that have been discussed with the relevant specialist clinicians / Partners, HDS and Wold Haven Residential Registered Manager.** In those cases, HDS will comprehensively document the clinical justification from deviating from the criteria and reflect these in any subsequent management plan or ceiling of care plan.

1. Medically unstable or at high risk of significant deterioration requiring close monitoring and intervention. Some features may include:

    - High Fever (>38.5 deg C)
    - Low oxygenation (<92% SaO2 on air) – exception for Long Term Conditions if parameters are identified in the care plan.
    - Abnormal Blood Gases
    - Tachycardia (heart rate >100bpm)
    - Unstable or low blood pressure (<90/66mmHg)
    - Reduced level of consciousness.
    - Abnormal and unqualified or rapidly changing results, e.g., falling haemoglobin, high white cell count, worsening renal function.
    - NEWS 2 score of 3 and above

2. It should be noted that where some of the above criteria are present but are stable then they may not necessarily exclude admission, subject to this been agreed by a senior doctor / senior practitioner and deemed as acceptable by the Wold Haven Residential Registered Manager.

3. Infections: Patients with a known or suspected contagious infection will only be accepted after approval from the Health Care Acquired Infection (HCAI) team and or Unit manager A clear plan is required to be in place alongside an isolation bed for the patient to be cared for in and deemed as acceptable by the Wold Haven Residential Registered Manager.

4. Complex functional illness requiring specialist care, including medical care (will include complex functional illness where there is a significant risk of harm). Patients in whom there has been an acute confusional state (delirium) related to a physical cause, e.g., an acute infection which is causing increased NEWS scores and indicates escalation, endocrinological imbalance and where further physical investigations are required.

5. Individuals who have complex functional or organic disorder who have been through the criminal justice system for behaviours resulting from illness and require care from a specialist forensic service.

6. Individuals with organic, functional, or mixed disorder who exhibit extremes of challenging behaviours including extreme physical violence, extreme sexual dis-inhibition.

7. Where no diagnosis can be offered and is requiring continued specialist services.

8. Access to complex, frequent or specialist diagnostic imaging services.

9. Specialist services that are provided elsewhere, e.g., mental health services.

10. Under 65 years of age.

11. Social respite (except patients who are in receipt of some aspects of palliative care and require a period of support to enable on-going care at home in end-of-life care).

12. Patients who require in-patient alcohol detoxification regimes.

4.4. Reporting on unsafe discharge or poor-quality Trusted Assessor Form (TAF):

- The Datix system is used to log unsafe discharges and escalate to partners as required.
- The Wold Haven Residential Senior Care Officers and Registered Manager will follow East Riding of Yorkshire Council procedure to report an unsafe discharge or poor-quality Trusted Assessor Forms.

Appendix 1 – Bed Form

Wold Haven HUB beds
3 beds available – please send a daily update to
hnf-tr.hospitaldischargeservice@nhs.net

Details	Hub 1	Hub 2	Hub 3
Status? *Available, Not Available, Occupied, Blocked*			
Occupant's initials			
Admission date			
Expected discharge date *(Based at time of admission)*			
Safe discharge to Hub?			
All information received as part of admision?			
Planned discharge date? *(If different to expected date)*			
Notes / Comments			

IPC issues or concerns?	
Pending admissions	