

**2.5 Enhanced Requirements for Discharge to Assess (DTA)**

This section clarifies the requirements for placements made under Discharge Pathway 3. The standards in here are in addition to the requirements made in the main body of the Service Specification, including the core Statements of Requirements and the Enhanced Requirements for Nursing.

Where there are differences between the main service specification, this document should be adhered to.

Please note that the main paragraph numbering/ headers read across to the core service specification

**The Pathway 3 definition relevant to this specification is that**

Home is not an option and the individual requires 24-hour bedded care. The person:

* + 1. Has such complex needs and/or has experienced a significant life changing event that they are
    2. likely to require 24-hour bedded nursing or residential care on an ongoing basis following a period of assessment (up to 4 weeks) of their long-term care needs.
    3. Will require their assessment undertaking whilst in a 24-hr bedded setting to facilitate choice in relation to their permanent placement

To note that placements under this specification do not include End of life – therefore clause iv ‘of the definition ‘Is at the end of their life and wants to die in a Care Home’ is not applicable here

1. **Outline**
   1. This Service is commissioned by City of Bradford Metropolitan District Council on behalf of the ICB.
   2. The Service will provide Discharge to Assess (DTA) beds into an Independent residential or nursing care home in the Bradford area under Pathway 3.
   3. The ambition is for people to be discharged within 24 hours of no longer meeting the Criteria to Reside between Monday to Friday.
   4. Delivery under this specification is not mandatory and homes are required to opt-in should they wish to be considered for a placement under DTA. By doing so, homes are agreeing to deliver the requirements of this schedule, and accept the contracted rate.
   5. The Service is aimed at securing rapid discharge from hospital for those people that do not require care and support in an acute setting, and meet the definition above.
   6. Placements under DTA Pathway 3 are short-term only and funded for a maximum of 4 weeks. After this time, the funding arrangements resume to the Council’s Standard Operating Procedure for long-term care, unless a Primary Health Need is identified during this time, in which case may be extended by 2 weeks. Following that period, the rate will revert to the Council’s published Care Home rates with any additional fees agreed under the Council’s Standard Operating Procedure .
   7. The placement may either be into a residential or nursing home, dependant on type of need.
   8. A full assessment should take place once a person has reached a point of recuperation, where it is possible to make an accurate assessment of their longer-term care needs. It is best practice to screen for CHC at the right time and in the right place for that individual. The assessment process for CHC should not be allowed to delay hospital discharge.
   9. Should a long-term placement be deemed necessary, it may be that a different care home is identified due to either capacity in the current placement, the ongoing cost of the placement or because of the assessed care needs.
   10. The DTA rate is all-inclusive and not negotiable. Top Ups cannot be applied during this placement.
   11. This is likely to affect approximately around 1% of people aged over 65 years being discharged from hospital.
2. **Pathway Description**

**Local Descriptor**

See Appendix 2 for BdC place discharge pathway definitions February 2024

**DOHSC Hospital Discharge and Community Support Guidance**

A full description of the pathways can be found at

[Hospital discharge and community support guidance - GOV.UK (www.gov.uk)](https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance)

**3. Legal Framework including national and local standards**

3.1 This document should be read in conjunction with the overarching Bradford and District Residential and Nursing Care Homes Provider List - Service Specification relating to the provision of these services, and which contains the full Statements of Requirements for delivery. The requirements for the delivery of these services and their relationship to CQC standards should be considered the minimum that providers should deliver in a standard residential or nursing home.

3.2 Where discharge is into a Nursing Home, the Nursing addendum should be read in conjunction with the Specification. Where there are additional or different requirements for people discharged under DTA, these are set out in this document.

3.3 Where there are differences between this and the main specification, this document should be adhered to until the placement under DTA ends, where it will then revert back to the main Specification.

**4.Partnership Working and Community Offer**

4.1 The model delivers an integrated partnership approach to assessment and delivery, with providers, hospitals (Bradford Teaching Hospitals NHS Foundation Trust and Airedale Hospital NHS Foundation Trust), GPs and the person and their family/carers.

4.2 There is no additional therapy input from Community Services during this period.

4.3 Where the placement is in a Residential Home, District Nursing will support if required.

4.4 People will receive medical support from the GP practice that is aligned to the Nursing or Residential Home.

*4.5 Discussions are taking place around additional wrap around support that can be provided during the assessment period from the Telemedicine Service and The Care Home Liaison Service’ and will be added prior to service commencement*

**5. Operation of DTA placements and call-off**

5.1 This service is open to Homes located within the Bradford District and are currently signed up to Bradford’s Provider List.

5.2 Homes are required to opt-in to the delivery of this Service via an Expression of Interest. By expressing an interest, homes are agreeing to deliver the requirements of this schedule at the agreed DTA rate.

5.3 To remain on the list, Homes must provide details of their currently weekly rate (i.e. the rate that they will charge once the DTA period has ceased) and inform the Commissioning Team of any large variations from this rate, as these rates will be taken into consideration at discharge.

5.4 Once approved, this list will be used by Hospital Discharge Teams to make placements and shared with families to enable decision-making with regards to the placement.

**Please see Section 13 - Pricing Schedule below for full details**

**6. Contract and Quality Assurance**

6.1 This is as outlined in the Quality Charter and main Service Specification.

**7. Services in Scope**

7.1 The Service will provide Discharge to Assess (DTA) beds into an independent residential or nursing care home setting within the Bradford district area.

**8. Delivery Requirements**

## 8.1 Access and Referral

## 8.1.1 Referral will be made to the Home from

## Bradford Royal Infirmary via the Multi Agency Integrated Discharge Team (MAIDT)

## Airedale General Hospital via the Discharge Flow Team

Known from here on as ‘the Referrers’

## *– see also Statement of Requirements section 9*

**8.2 Eligibility**

8.2.1 People deemed as eligible for a DTA placement meet the definition for Pathway 3 above- bar the exclusions below.

**8.3 Exclusions**

8.3.1 People must not be in need of acute medical intervention with intravenous therapy or regular monitoring of an unstable medical condition, unless agreed with support partners on a case by case basis.

8.3.2 People who are at end of life choosing to die in a Care Home won’t require the assessment period so discharge will be arranged directly with the homes.

**8.4 Hours of Operation**

8.4.1 The Hospitals aim to discharge people within 24 hours of them no longer meeting the Criteria to Reside to remain in a hospital bed.

8.4.2 Homes are required to meet this target between Monday to Friday.

8.4.3 Where it is safe to do so, Homes may accept discharges over the weekend, but it is not a requirement of this service.

8.4.4 The Provider must have a senior member of staff available to agree referrals via secure email between 830am and 4pm, Monday to Friday. Where the Home Manager or dedicated staff member is not available to review referrals, it is expected that the home will nominate an on-call manager to accept/reject referrals and agree admissions.

**9. Statement of Requirements for Homes**

*Please read this section in conjunction with the Statement Requirements in the main Service Specification and addendums*

**9.1 Access and Referral**

**9.1.1 Referral and Assessment**

***S****ee also Statement of Requirements section 9*

9.1.1.1 The Referrers will identify people who are medically optimised for discharge and who are suitable discharge under pathway 3 discharge to assess in for a care home setting.

9.1.1.2 The expectation is that admissions will be coordinated and completed by the Local Authority Trusted Assessor (TA), including an assessment provided by the Social Worker to sufficiently identify that a residential or nursing placement will be required. [20180625\_900805\_Guidance\_on\_Trusted\_Assessors\_agreements\_v2.pdf (cqc.org.uk)](https://www.cqc.org.uk/sites/default/files/20180625_900805_Guidance_on_Trusted_Assessors_agreements_v2.pdf)

9.1.1.3 The information in this assessment must be fit for purpose and an accurate reflection of the person’s needs, risk and behaviour.

9.1.1.4 The hospital discharge teams will determine if a person has any nursing needs and this will inform decision making in relation to the type of placement required.

9.1.1.5 The Social Worker (or allocated worker) will discuss with the person and their carers/families/significant others the move to a care home for a short-term placement, where a full assessment of their care needs can be completed. It will be made clear that this is a short-term placement. This includes the issue of Personal Choice Contributions (Tops Ups) after 4 weeks, should the person move on to a chargeable service. The guidance leaflet should be included in the pack. This should also include information regarding CHC eligibility and that top-ups are not permissible but that CHC eligibility is reviewable.

9.1.1.6 The referral and assessment information will be sent directly to the identified Home who will have provided a secure form of email communication.

9.1.1.7 The Provider must review the referral and accept/reject within 1- 2 hours. If no response, is received within this timeframe, another Provider may be approached.

9.1.1.8 It is expected that the assessment coordinated by the TAs will in most cases be accepted by the Home, and the Home will provide updates (see section 11 for information recording).

9.1.1.9 Homes may conduct their own assessment, taking into account the ambition to discharge within 24 hours.

9.1.1.10 The Provider will aim to admit the person into the home before 5pm the same day.

9.1.1.11 The Provider should seek clarification if it is unclear from the referral whether the person meets the criteria for admission, or where there is uncertainty that the person’s needs can be met, the Provider should discuss this directly with the referrer to clarify and aim to resolve in line within 1-2 hours.

9.1.1.12 If the Provider is unable to accept the referral or it is inappropriate, this should be fedback to the referrer within the 1-2 hour timeframe.

9.1.1.13 If there are any issues or concerns post discharge into the home such as missing information or medication concerns, this should be escalated in the first instance to the ward where the person is discharged from. If an appropriate resolution is not achieved, then concerns can be escalated to the Discharge Team Leads

9.1.1.14 There should be no more than 1 admission into a home in any 24-hour period, with a maximum of 2 admissions in a week.The referrer and the Home should also take into consideration how many placements have been made into a single home overall – a high number of DTA placements into one home is not advisable and can pose a risk to the home as well as increasing pressure on GPS and DNs.

9.1.1.15 The Home will take into account the total needs of the other residents at the time.

9.1.1.16 The TAs need to ensure that the individual and their family and friends understand at the point of referral that funding for this placement is short-term only. Should they wish to stay on at that home after the period of assessment, then a Personal Choice Contribution (Top Up) may be applied.

9.1.1.17 Following the period of DTA - where the Home’s ongoing rate is over the Council’s base rate, families need to be made aware that they will need to pay the additional top-up (and the cost of it) if they are not eligible for CHC post 4 weeks, or the Council will look to place in alternative homes that offer at the Council’s base rate. **This discussion needs to take place before the DTA placement is made.** These costs will not be met by the Council.

9.1.1.18 Homes will inform us of the current PCC / Top Up over the Base Rate so that families can make an informed choice prior to the initial admission.

9.1.1.20 In line with the Care Act and the department’s standard operating procedure, families must be offered at least one choice of home at Base Rate.

**9.1.2. Leaving Hospital**

9.1.2.1 On acceptance, the ward team will arrange transport and medication if required. The Allocated Worker will confirm transport arrangements and the estimated arrival time with the Provider.

9.1.2.2 The Allocated Worker must ensure the individual is not discharged without

A list of current medication

7 days of medication and/ or dressing

Their discharge summary

An inventory of personal belongings

Any essential equipment in place

9.1.2.3 Oxygen should be in situ before the person leaves the hospital setting. If the person has an ongoing need for oxygen, the respiratory nurse organises this and sends the information to the Home. People that are insulin dependent or who require other essential medications must have the relevant medication with them on discharge, and the provider must inform any residential community teams involved where needed.

9.1.2.4 It is the ward’s responsibility to make referrals to the DN's for in-reach support to the DTA beds.

9.1.2.5 DNAR information and RESPECT documentation will be provided by the ward if appropriate. The provider will ensure this is in place, if relevant, and maintained alongside the advanced care plan. Providers will need to request a review by the GP Practice if a person’s condition changes or deteriorates during their stay

**9.1.3 Admission**

9.1.3.1 The admission of a person should ideally take place before 5pm on the day of referral, preferably within 2 hours of acceptance.

9.1.3.2 People must be temporarily registered with the Provider’s usual GP surgery within 24 - 48 hours of admission to the home. If admission takes place after 5pm on a Friday, or on a weekend/bank holiday when the surgery will not be open, the Provider will be expected to register the person on the next working day. ***Please note GP discussions are ongoing***

9.1.3.3 The Provider must check that the person has a discharge summary and items listed at 9.1 above on arrival - should these not be included, the Provider must contact the ward in the first instance and escalate to the Discharge Leads via if no resolution is achieved

9.1.3.4 The Provider should keep a log of all admissions and discharges.

9.1.3.5 The Provider should email the following information to their GP surgery within 24- 48 hours of admission:

* A patient registration form for temporary registration, annotated to highlight that the patient is in a DTA bed;
* A copy of the discharge letter
* A copy of the current MAR chart being used.

9.1.3.6 Within 24-48 hours of admission, the Provider should send a copy of the discharge letter via email to their pharmacy or (temp) GP to manage the medication.

9.1.3.7 The Provider shall begin the assessment (with focus on night-time needs if applicable), and ensure the person has a care plan in place including risk assessments, within 24 hours of admission.

9.1.3.8 Upon admission, the person’s Social Worker will begin the social care assessments within 14 days. A full Care Act and Financial Assessment should then be completed within a further 14 days and an estimated discharge date and destination will be set.

9.1.3.9 The allocated social worker should also consider a referral to CHC with a checklist if it is felt necessary. This should be completed by day 14 of admission.

9.1.3.10 If eligible the DST assessment will need to take place between CHC and social worker within 28 days.

9.1.3.11 If it is identified through the assessment that the person can return home but requires home adaptations or equipment to support their discharge home, this will be referred to the relevant services by the allocated Social Care Assessor.

9.1.3.12 Hospital staff will ensure people and their carers/families/significant others are provided with information prior to discharge from an acute setting regarding the DTA bed model, including the Trust ‘Moving On’ letters. The purpose of the information is to set expectations.

9.1.3.13 The Provider must also ensure that the person and their carers/ families/ significant others are given clear guidance in writing on the bed model to set expectations including additional fees that may become payable at the end of the DTA funding.

9.1.1.3.14 Any post-discharge issues experienced after the first 24hrs post discharge should be escalated to the named Social Workers by the Home *– contact details to be confirmed*

* + 1. **Choice, Control and Engagement**

9.1.4.1 For the purposes of this addendum, it is a requirement that Providers must be able to access Telemeds and other health related professional referrals and pathways.

**9.1.5 Assessment and Care Planning**

9.1.5.1 Care plans will support people to maintain, learn or relearn the skills necessary for daily living.

9.1.5.2 Progress will be reviewed on a daily basis by staff involved in the delivery of support services, including the ongoing need for any 1:1 support. This will involve ongoing collaboration between different professionals, with efforts co-ordinated to ensure the care plan is implemented in a timely manner and plans are put in place to meet the expected discharge date. Daily notes must be comprehensive and record all activity to inform the assessment of needs.

9.1.5.3 Where it is identified that there is no longer a need for 1:1 care, the Provider must inform the named Social Worker immediately.

9.1.5.4 Care and support plans and risk assessments must be maintained on a dynamic basis and reviewed weekly by the Provider.

9.1.5.5 Advance care plans must be recorded in a way that is useful for healthcare professionals in an emergency situation. If an advance care plan is already in place, the Provider will request a copy. If there is no advance care plan, the Provider must ensure that a basic end of life plan is in place within 24 hours of admission, and an advanced care plan completed within 72 hours of admission. A paper copy should be filed in the care home records, and where the facility already exists, an electronic version should be shared with relevant services. Please note that this section is being reviewed.

9.1.5.6 The Provider will facilitate regular review meetings for each person, with all the relevant professionals included. This may take the form of a virtual MDT meeting, where appropriate.

9.1.5.7 Meetings organised by the Social Worker will review the progress achieved by the person and the actions that need to be taken to ensure timely discharge. This may take the form of virtual and/or face to face meetings. It is the Provider/Home Manager’s responsibility to update the tracking spreadsheet at or after each of these review meetings, which must be shared with nominated Social Worker on a weekly basis.

9.1.5.8 If a person remains in the DTA bed past 6 weeks, the home shall convert to full care and support plans including all risk assessments.

9.1.5.9 The Discharge Improvement Notification is intended as a learning tool and should be used by Providers, District Nurses and IAH where there has been an issue with the discharge process, and a review needs to take place in order to improve processes going forward.

**9.1.6 Moving On/ Transitions in Care**

9.1.6.1 A transfer may only take place once the Care Act and Financial assessments have been completed and an appropriate ongoing care plan has been established. This should ideally be within 14 days and no longer than 28 days.

9.1.6.2 Where the outcome of the assessment is that full-time residential care is needed, the Council’s Standard Operating Procedure will then be followed. Families may be liable for a Top Up in the current home – this discussion needs to be revisited as a priority. A new ISA will be issued.

9.1.6.3 Should a different Home be identified for the long-term placement, the Social worker will inform the Home of the moving date.

9.1.6.4 The provider will ensure accurate, detailed records are maintained throughout the duration of the placement and made available to support any onward care needs. Good records will need to be kept re function and need to support the assessment. (See also section 11 below)

9.1.6.5 If a person is discharged from a DTA bed to a permanent bed within the Provider’s care home, the Provider should complete a permanent registration form (with the individual’s consent) and send via email to the relevant GP surgery within 24 hours.

9.1.6.6 The Provider must notify their GP in writing as soon as a temporary person has been discharged from the care home.

9.1.6.7 The Provider must notify their GP surgery as soon as a date is confirmed for a person to be discharged, to allow the GP to prescribe any medication that is required.

9.1.6.8 It should be noted that the Social Worker will be responsible for encouraging patient flow in the discharge process. All partners including the Provider will assist in the transfer of assessment information to improve patient flow.

**9.1.7 Re-admittance to Hospital**

9.1.7.1 If a person is readmitted to hospital, it is the Provider’s responsibility to notify the Social Worker within 24 hours and give the reason for the admission. This will result in a discussion of whether a return to the DTA bed is appropriate. If the person is not returned to the home within 48 hours, the Provider is to escalate to the allocated Social Worker to ensure maximum capacity is maintained.

**9.1.8 Health and wellbeing**

9.1.8.1 The provider must have a comprehensive admission and assessment process which as a minimum includes; body mapping, nutrition screening, falls risk assessment and management plan

9.1.8.2 If a person is admitted to the home with a pressure ulcer grade 3 or above, the Provider must complete an internal incident form and CQC notification and then escalate to the named Social Worker

9.1.8.3 On discharge, the Provider will provide an up to date list of current medication and 7 days’ supply of medication if applicable

**10 Staffing Requirement**

10.1 The Provider will nominate dedicated management, nursing and/or care staff to promote an enablement focus and ensure continuity of care. This will foster good working relationships and increase communication pathways with the Provider staff team and multi-disciplinary teams visiting the home.

**11.Information Reporting**

***To be read in conjunction with 9.1.5 and 9.1.6 above***

11.1 Progress will be reviewed on a daily basis by staff involved in the delivery of support services. Daily notes must be comprehensive and record all activity to inform the assessment of needs.

11.2 Care and support plans and risk assessments must be maintained on a dynamic basis and reviewed weekly by the Provider.

11.3 It is the responsibility of the Provider to keep Capacity Tracker up to date on a dynamic basis, not less than weekly, to ensure accurate occupancy and admission status is known.

11.4 Social Work and Trusted Assessor teams utilise the vacancy map which draws data from the Capacity Tracker each Wednesday. **Updating the Capacity Tracker** **by the end of Tuesday each week** will ensure your care home appears on the map with up to date vacancy information for that week.

11.5 The Provider is expected to keep detailed care and support records in order to inform the Care Act Assessment and any Decision Support Tool. This should include records detailing 1:1 support that has been agreed to facilitate DTA

1. **Pricing Schedule**

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| --- | --- |
| Residential | £807.24 p/week |
| Nursing | £1089.76 p/week |

**Funding Requirements**

12.1 The published DTA rate is all inclusive and non-negotiable.

12.2 This period is non-chargeable to the resident and/ or their family and Top-Ups/ PCC/ non-Healthcare charges may not be applied during the assessment period.

12.3 Where 1:1 support is needed, this should be agreed on a case-by-case basis. This may be decreased/ removed during the assessment period following review by the Social Worker.

12.4 Placements under Pathway 3 are funded by the ICB for a maximum of 4 weeks to allow an assessment of longer-term needs to take place.

12.5 Checklists for DST are to be completed by the Social Worker by Day 14. The ICB will then complete the full DST ideally with 28 days of receipt. Where the resident has had their DTA non chargeable period and/ or their eligibility for long-term needs have been established, but have a DST pending, the LA will complete the Care Act and financial assessments and charge the person on the understanding that if they are found to have a Primary Health Need, any charges will be reimbursed by the ICB.

12.6 If there is a delay on the part of the Council or ICB in undertaking these assessments, then the DTA period may be extended by a maximum of another to weeks (6 weeks total). After 6 weeks, the Home will move to their usual weekly rate. The placement will then be funded by the organisation which still has to complete the assessment.

12.7 If it is agreed that a person should be discharged from the DTA bed to a long/temporary stay bed either within the Provider’s care home or another home, then the Standard Operating Procedure will apply. This includes completion of a new Individual Service Agreement. No notice period is needed.

12.8 Where the Home’s ongoing rate is over the Council’s base rate, families need to be made aware that they will need to pay the additional top-up (and the cost of it) if they are not eligible for CHC post 4 weeks, or the Council will look to place in alternative homes that offer at the Council’s base rate. **This discussion needs to take place before the DTA placement is made.**

12.9 For people who are eligible for Bradford Council funded care, the long-term placement should be agreed at the standard fee rates, and the normal charging policy should apply. If there is a Top Up payment agreement must be obtained from a third party by the SW and relevant contractual paperwork written and signed by all parties.

12.10 For FNC or CHC funding, this will be agreed following an assessment which will take place whilst the person is in the DTA bed. The Provider will be given clear dates for funding transfer.

12.11 As part of their return, Homes must also detail their current weekly rate (i.e. the rate that they will charge once the DTA period has ceased). Homes must inform the Commissioning Team of any large variations from this rate, as these rates will be taken into consideration at discharge by both the Discharge team and families.

12.12 Discharge Teams should check the current rate with the Home at the time of any placement.

12.13 Should the home fail to inform the Council of any changes, it is expected that the placement will continue on the last rate received.

12.14 For people who self-fund their care, any negotiation of an ongoing fee rate should be supported by the Social Worker but agreed between the Provider, service user and their family.

12.15 Where a different home has been identified for the long-term placement (see Moving On’ - the Social Worker will inform the Home of the moving date. No separate notice period is needed to the Home.

12.16 Payments are calculated on a daily basis.

**APPENDIX 1 - DTA Individual Service Agreement (ISA)**

**To be included here**

**Appendix 2 BdC place discharge pathway definitions February 2024**

|  | **Acute Trust Sitrep reporting** | **Place discharge definition** |
| --- | --- | --- |
| **P0** | a) Pathway 0: Domestic home  (no active support needed)  b) Pathway 0: Domestic setting - Other place (no active support needed)  Soon to include people discharged back to a Care Home if this was their usual place of residence. | Discharged home or to a usual place of residence with no new or additional health and/or social care needs.  The person:   * Has no new additional support needs to get back to their home, Care Home (residential or nursing) or other domestic setting. * Can return home or other domestic setting with a continuation of an existing health (e.g., District Nurse) and/or social care package that remained active whilst they were in hospital. * Has minimal support needs that can be met informally by support agencies e.g., Home from Hospital and Multi Agency Support Team etc.   Likely to be around 50% of people aged over 65 years |

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| --- | --- | --- |
|  | **Acute Trust Sitrep reporting** | **Place discharge definition** |
| **P1** | c) Pathway 1: Domestic home (active support needed)  d) Pathway 1: Domestic setting - Other place (active support needed)  e) Pathway 1: Hotel (active support needed) | Discharged home or to a usual place of residence with new or additional health and/or social care needs.  The person:   * Already has an existing package of care (POC) which requires increasing and will be subject to ongoing review post discharge. * Already had an existing POC but this lapsed whilst they were in hospital and will need restarting. * Requires a new POC which can be delivered directly from the Independent Sector as individual has no reablement requirements. * Requires short term (up to 6 weeks) enablement support from the Bradford Enablement Support Team (BEST) or the North Yorkshire Reablement Service. * May/may not require a POC but needs Community Therapy and/or Community Nursing interventions that weren’t being delivered previously pre-admission e.g., interventions like administration of insulin, support with end-of-life care needs (syringe driver) * Is at the end of their life and wants to die at home**.**   Likely to be around 45% of people aged over 65 years |

|  |  |  |
| --- | --- | --- |
|  | **Acute Trust Sitrep reporting** | **Place discharge definition** |
| **P2** | f) Pathway 2: Care Home (rehab or short-term 24-hour care before return home)  g) Pathway 2: Designated Setting (before moving to 24-hour bed-based setting)  h) Pathway 2: Hospice (short term 24-hour bedded support)  i) Pathway 2: Community Rehab Bed (rehab or short-term 24-hour care before return home) | Requires short-term intensive support in a 24-hour bedded setting.  The person:   * May require rehabilitation with immediate and ongoing therapy assessment and delivery of therapeutic interventions. * May require a period of ongoing assessment to determine their future care/support needs to get them back home. * Would benefit from reablement approaches to promote independence and aid long-term recovery. * Likely to be able to return home independently or with additional support e.g., package of care. * Is at the end of their life and requires hospice care.   Likely to be around 4% of people aged over 65 years |

|  |  |  |
| --- | --- | --- |
|  | **Acute Trust Sitrep reporting** | **Place discharge definition** |
| **P3** | j) Pathway 3: Care Home (new admission, likely to be permanent  k) Pathway 3: Care Home (existing resident discharged back to Care Home – soon changing to P0)  l) Pathway 3: Designated Setting (before new likely permanent admission to Care Home) | Discharged to a new residential or nursing home setting, for people who are considered likely to need long-term residential or nursing home care. Should be used only in exceptional circumstances.  The person:   * Has such complex needs and/or has experienced a significant life changing event that they are likely to require 24 hour bedded nursing or residential care on an ongoing basis following a period of assessment (up to 4 weeks) of their long-term ongoing care needs. * Will require their assessment undertaking whilst in a 24-hr bedded setting to facilitate choice in relation to their permanent placement. * Is at the end of their life and wants to die in a Care Home.   Likely to be around 1% of people aged over 65 years |