Intermediate Care & Frailty Single Point of Access – Referrals

Referrals from Hospital Discharge Teams & Other Specialist Hospital Teams, in the circumstances outlined below:

- Discharge to Assess Model Pathways
  - Pathway 1 (Reablement/D2A)
  - Pathway 2 (Intermediate Care Bed)
- Complex Community Patients - Frailty

NB. Hospital Discharge Teams will assist ward staff with the identification of patient's most appropriate discharge

Urgent Care Single Point of Access (SPA)

8am – 8pm Monday – Friday & 9am – 5pm Saturday/Sunday

See acceptance criteria into SPA overleaf

NB. SPA to screen referral and determine the appropriate pathway.

Referrals from community sources:

- GPs;
- Social care;
- Voluntary agencies
- Health care professionals, e.g. District Nurses, Community Matron;
- NWAS (via Paramedic Route).

Where enhanced assessment, clinical intervention etc. may be required.

Reablement First (D2A)

Caseload: 45-50

Rehabilitation (IC bed)

Caseload: 12-19

Community Rapid Response

Caseload: 20-25

No further intervention required and discharged from SPA:

- Not medically stable
- Discharge independent
- Onward referral (e.g. voluntary sector, reinstate Long Term Care package, inc. a Long Term Care Placement)

Acceptance Criteria into SPA for Referrals:

1. Age 18+; and
2. Registered with a Halton GP **or** Resident of Halton Borough.

NOTE: This criteria is inclusive of Service Users with a mild to moderate Dementia diagnosis/ individuals with learning disabilities.

Pathways into Community Services (Guidance):

Reablement First (Discharge to Assess): *Community Based Multi-Disciplinary Interventions*

- Home environment is suitable/conducive for assessments/interventions by MDT (Physio, OT, Nurse, Therapy Assistant or Social Care);
- Does not require 24 hour care support during Intermediate Care interventions, but may require a Reablement care package in own home during Intermediate Care Service intervention;
- Does not require nursing supervision/interventions over a 24-hour period, but can access nursing dependent on need

Rehabilitation (IC Bed): *Bed Based Multi-Disciplinary Interventions*

- Home environment not suitable/conducive for assessments/interventions by MDT;
- Require 24 hour care support during Intermediate Care interventions;
- Nursing supervision/interventions may be required;
- Some investigations/interventions required aren't available in the community e.g. GP overview etc;
- Requires a period of assessment following discharge from hospital or other care setting e.g. transitional care to determine long term care needs/placement;
- Those patients with a Plaster of Paris/splint in place or who are unable to fully weight bear for a number of weeks following orthopaedic intervention;
- Early Supported Discharge (ESD) Stroke Pathway, based on category within the Pathway (Categories 1 and 5 excluded). NB. ESD Team would provide interventions as prescribed in the Stroke Rehabilitation Pathway.

Community Rapid Response (CRR)

This CRR will respond when people are:-

- Experiencing a crisis.
- At risk of hospital attendance/admission or residential care admissions.
- Medically safe to be treated/cared for in a community setting.
- In need of assessment/intervention with two hours (safe to wait for up to 2 hours).
- Returning home from hospital and who may need extra support.

No further intervention required and discharged from SPA

- ***Not Medically Stable*** e.g.
  - Service User requires Acute hospital admission e.g. suspected fracture, chest pain;
  - Service User requires medical interventions which are not available in the Community;
  - Practitioner's clinical judgement based on information available e.g. history and observations.
- ***Independent***
- ***Onward referral*** e.g.
  - Voluntary Sector support;
  - Respite Care, Long Term adaptation or reinstatement of a long term package of care only required