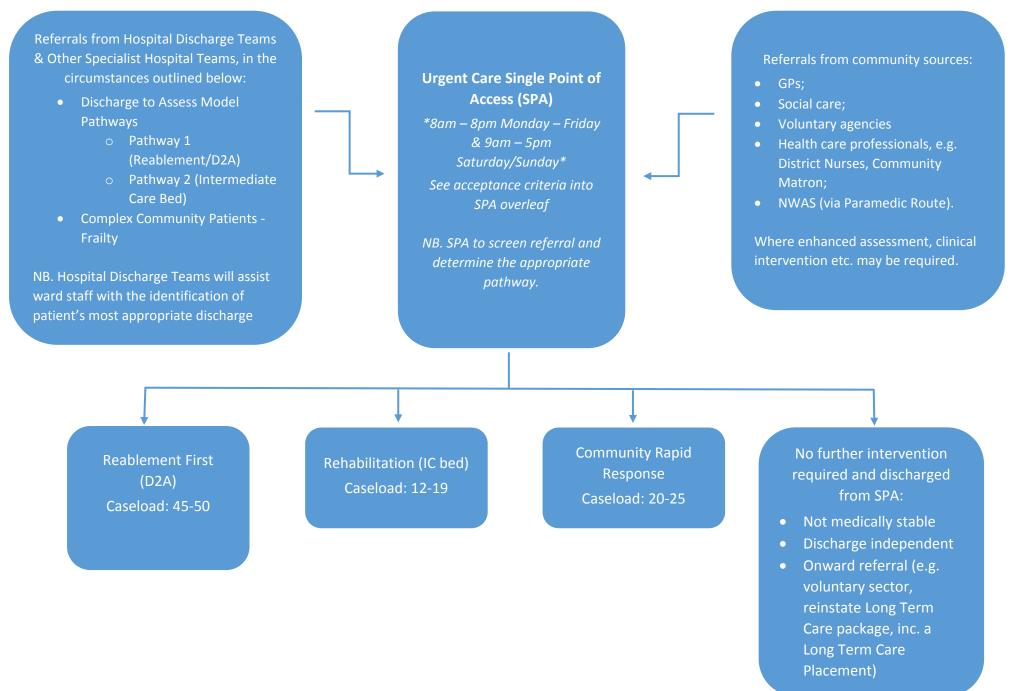
### Appendix 2

# Intermediate Care & Frailty Single Point of Access – Referrals



# 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