Appendix 3

Overview of Pathways

Pathway 0	Pathway 1	Pathway 2	Pathway 3
•Patient returns to usual place of residence •Fully independent-no further support required •Restart package of care (POC) with no changes •Has pre-exisiting community services in place •may require support from VCSO/Age UK (contract in place)	•Patient returns to usual place of residency with interim support (provided by the Reablement Team). •New POC or increase of exisiting package. •Temporary reablement to maximise indepence. •Assessement of some additional care and support (including therapy, nursing, domiciliary care and/or new equipment •The individual is safe between calls/overnight.	•Patient is transferred to a non-acute bed (community) and receives rehab and assessment until able to return safely home. •Short term bedded rehab with or without reablement and assessment •Unsafe to be at home overnight/between care calls •Includes specialist rehabilitation	•Patient is transferred to a new long-term bed/assessment and receives complex support and/or assessment for their needs •Complex/significant health and/or social needs which require a new placement •Life changing health care needs •Complex end of life of mental health needs •Complex housing and homeless needs •Requires live in care with multi professional input

The National Audit of Intermediate Care (NAIC) undertaken in 2018/19 collected data from providers and found that 'HomeFirst' should be the default for all patients. The audit stated that at least 95% of over 65's leaving hospital should be going straight home/ normal place of residence, either on pathway 0 or pathway 1. From September 2020, up to 6 weeks reablement at home has been funded where it is completely new; or for any additional reablement services which are added to a pre-existing care package.

For the very small number of people who really cannot go straight home and need rehabilitation in a community bed (Pathway 2), the aim is to get them home as soon as possible. If they then require some further enablement on their return home, additional to any pre-existing care package, this is funded for up to 6 weeks.

Pathway 3 – is for less than 1% of individuals admitted where 24-hour care in a nursing home is required, probably on a permanent basis.

The primary outcome from navigating through the pathways in a collaborative manner is to reduce the use of acute beds, have shorter lengths of stay in hospital, provide system cost savings, and most importantly improve the overall patient experience by promoting 'HomeFirst' where appropriate.