NHS Dorset Clinical Commissioning Group

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Integrated Primary and Community Services

Community Short Term Beds for Rehabilitation, Reablement and End of Life Care: Key Features and Functions



Supporting people in Dorset to lead healthier lives

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Contents

Introduction

Sustainability and Transformation Plan for local health and care

Our Dorset (Sustainability and Transformation Plan) sets out the vision for Dorset's health and social care systems. It describes three programmes of work:

1. **The Prevention at Scale programme** will help people to stay healthy and avoid getting unwell
2. **The Integrated Community Services programme** will support individuals who are unwell, by providing high quality care at home and in community settings.
3. **The One Acute Network programme** will help those who need the most specialist health and care support, through a single acute care system across the whole country.

Supported by two enabling programmes:

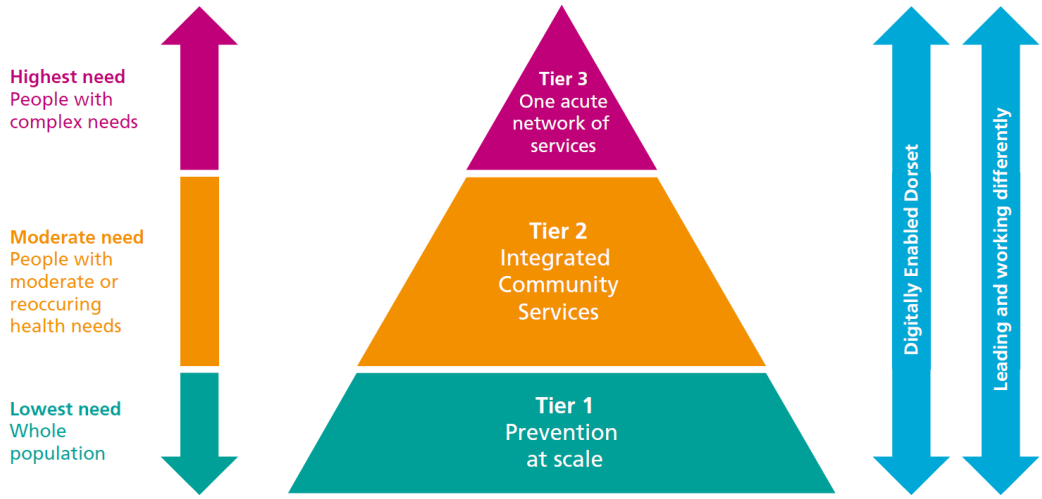
- The Leading and Working Differently programme focuses on giving the health and care workforce the skills and expertise needed to deliver new models of care in an integrated health and care system
- The Digitally-Enabled Dorset programme will increase the use of technology in the health and care system, to support new approaches to service delivery.

Dorset 's health and care system is working together to deliver this five-year plan in order to meet national priorities in line with the scale of change required and to close the gaps in health and well-being, care and quality, and finance and efficiency.

A needs-based approach to our interconnected programmes of work has been taken and is being supported by two enabling programmes:

- Leading and working differently – focusing on giving the health and care workforce the skills and expertise needed to deliver new models of care.
- Digitally-enabled Dorset – to harness the power of technology and support digital innovation to support new approaches to service delivery.

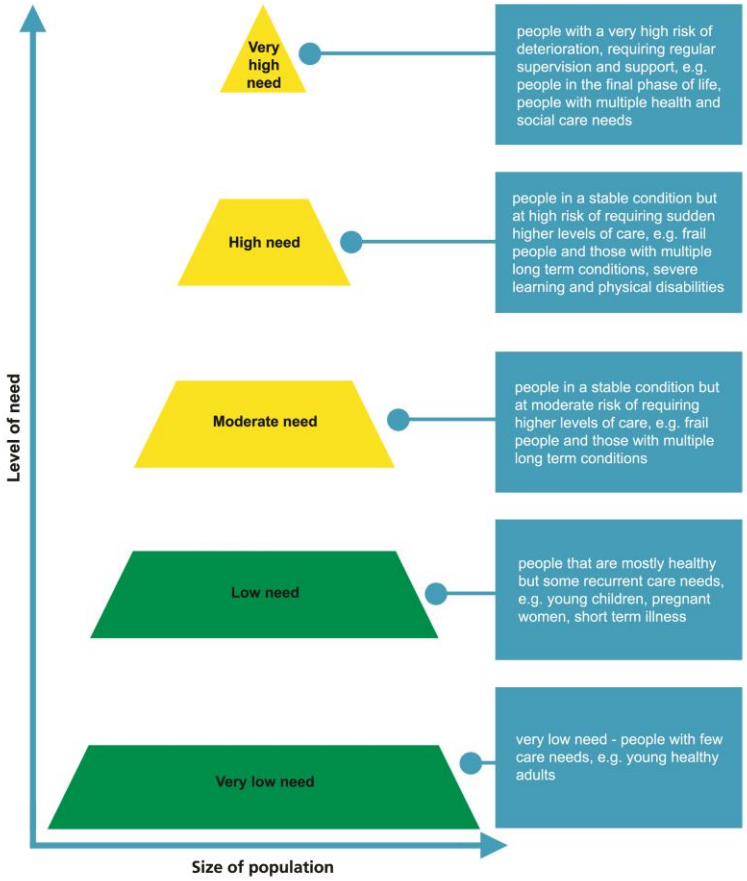
Figure 1: Diagram showing the three tiers of care in the new model. ICS forms tier 2.



What do we mean by Integrated Community Services (ICS)?

Integrated community services from the middle tier of our plan (fig 1 diagram middle tier and fig 2 below). This programme will transform general practice, primary and community health and care services in Dorset so that they are truly integrated and based on the needs of the local populations.

Figure 2: Diagram showing the ICS model



Community based services will be led by multidisciplinary teams of health and care professionals, working together to meet the needs of people who have short-term health needs, individuals with long-term conditions and those requiring specialist care for severe or complex health needs. We will deliver all of these services in a way that makes it easier for people to access care when and where they need to, with a consistent and high-quality experience for patients as they move between different parts of the integrated system. Our priorities are to:

- Support people to better manage their own health, with access to appropriate information and support – we expect a 10% reduction in new outpatient attendances and a 25% reduction in follow-ups.
- Provide care that is based on the needs of our local population, with services delivered at the times and places people need them.
- Enable more people to receive care at home and in the community, and to self-manage long-term conditions, to avoid having to visit hospital or being admitted as an inpatient – we expect to reduce 25% unplanned emergency medical admissions and unplanned surgical admissions by 20%.
- Make sure our community services are able to support frail older people with long-term conditions so that more care can be delivered closer to home.
- Improve personalised care for people with complex needs, including individuals with learning disabilities.
- Adopt new technologies that will support a high quality, consistent patient experience throughout the health system, with standardised working practices and seamless communication between health professionals.
- Create integrated teams of professionals with the right skill mix (including students) in improved working environments, to support the delivery of the model of care as well as enhance skills acquisition and personal development opportunities.
- Make sure that our NHS buildings, resources and finances are used in a cost-efficient way, including by planning care on a larger scale to achieve cost savings. (Sustainability and Transformation Plan)

Purpose of short-term care home and community hub beds

Building on the above ambitions, it is important to note that nursing care and rehabilitation will primarily be delivered within a person's home wherever possible and that referral to a short-term care home/community hub will only be necessary for a defined cohort of people.

The purpose of commissioning short term beds in care homes and community hubs is to provide step up and step-down rehabilitation, reablement and end of life care and support within a defined timeline for patients who are unable to receive this service at home or where admittance to an acute hospital ward is not required.

Definitions

Community beds for short term rehabilitation, reablement or end of life care will be available across the County within community hubs with beds or in locality care homes where the service is commissioned.

Community short term care home beds for Rehabilitation, Reablement and end of life care (step up, step down or transition) will be available in areas of the county where there is a community hub without beds but it is recognised that there is a requirement for residential beds with suitably trained and skilled staff to accommodate a small number of patients who require a period of care and support related to their rehabilitation or reablement goals or at the end of life. The provision of these beds will form part of a range of options to support people's different levels of need whilst providing care and support close to home.

The beds will be provided to support the philosophy of Reablement, Rehabilitation and End of Life (EOL) care which promotes the independence of the patient to lead the life they wish thereby reducing their dependency on support packages through the use of a reabling approach, ensuring that the customer and their families, relatives or carers:

- Are fully aware of the purpose of their short-term placement, has agreed the outcomes and are committed to returning home;
- Are supported to return home following their short stay in a care home bed;
- Will have the opportunity to engage in conversation with staff and other residents;
- Will be recognised as a contributor to the delivery of their own joint Care and Support Plan;
- Will identify their outcomes or by Best Interest Decision Making should the individual be unable to identify their chosen outcomes themselves;
- Are recognised that they are able (with capacity) to make their own choices and decisions regarding risk with the support and advice of others where required.

The World Health Organisation states that rehabilitation intervention should be aimed at achieving the following broad objectives:

- Preventing the loss of function
- Slowing the rate of loss of function
- Improving or restoring function
- Compensating for lost function
- Maintaining current function

These principles apply in a holistic way to encompass both physical and mental health *NHS England Commissioning Guidance for Rehabilitation 2016.* In addition, the provision of rehabilitation and reablement beds should be;

- Targeted at people who would otherwise face prolonged hospital stay or inappropriate admissions to acute inpatient care or long-term residential care;
- Provided on the basis of a comprehensive assessment, resulting in a structured individual care plan;
- Have a planned outcome of maximising independence and typically enabling patients to resume living at home;
- Are time-limited, the expected time frame being within 2 weeks and normally no longer than 6 weeks;
- Involve cross-professional/ agency working

Intermediate Care: Halfway Home (Department of Health, 2009)

What are our aims?

The model of care for Community short term beds:

Community beds for rehabilitation, reablement and end of life care will be primarily used to support frail and older people with rehabilitation or end of life care needs that cannot be managed within their own home environment.

Nursing and rehabilitation will be provided by the Integrated Community Teams (rehab and/or nursing) who will wrap the care around the patients wherever they need it i.e. at home or in a short-term care home/hub bed thereby supporting the patient to achieve their goals and minimising hand – off or hand over to other services.

Patients being admitted to short term care home for rehabilitation, reablement or end of life care would need to be those patients who are not likely to experience rapid deterioration as there will not be on-site access to diagnostics and a lower level of medical and nursing ratios than that provided with community hubs with beds.

Residential Home or Nursing Home?

When commissioning short term care home beds, consideration should be given to the following;

Residential care homes:

- Range in size from very small homes with few beds to large-scale facilities;
- Offer care and support throughout the day and night;
- Staff help with washing, dressing, at meal times and with using the toilet

Nursing Homes:

- Typically offers the same range of services as a residential care home with the addition of:
    - 24-hour cover from a registered nurse

Beds within a Nursing Home are the preferred model of delivery for rehabilitation and reablement due to the need for specific nursing care and monitoring over the 24-hour period. However, there are many dual registered establishments offering non-nursing and nursing care which would also be appropriate particularly for patients with reablement goals, palliative and End of Life care needs.

Short term community care home beds for rehabilitation, reablement and end of life care will be purchased as per the specific needs of each Locality. The number of beds for end of life care may be

different east to west of county due to the number of specialist palliative care beds already available for the east population.

Beds will be sited together in each care home to enable a rehabilitation and recovery ethos for patients, their families and carers, Nursing Home staff and wrap around community in reach Rehabilitation and Nursing staff. Siting beds together will deliver greater efficiency than beds spread across a locality and enable training to be delivered and expertise to be gained within commissioned care home beds.

It is expected that there will be a minimum of five beds available at any one care home as working at scale delivers efficiencies. Setting a minimum number of beds in any one care home supports:

- Effective and efficient working from visiting therapists and social care staff including reduced travel time
- Improves the relationships between visiting staff and care home staff
- Improves the skill set within the provider care homes.

Functions and Features of short-term Community Beds for Rehabilitation, Reablement and End of Life Care

The beds shall operate 24 hours per day and will enable the delivery of:

a) Reablement for people with complex social care needs who require promotion of independence and development of life skills, that cannot be managed and delivered adequately and safely in their own home, due to the level of complexity and intensity of their needs;

b) Rehabilitation for patients with complex healthcare and/or intensive rehabilitation needs that cannot be managed and delivered adequately and safely in their own home, and do not require the specialist medical assessment and interventions provided by an admission to an acute hospital;

c) Care for patients referred from either the community (traditionally known as “step-up care”) and from acute or specialist hospitals (traditionally known as “step-down care”), aiming for an increase in the use of step up beds.

d) End of Life Care for patients who have identified that they would like to spend their last days of life in a care home supported by staff that they know from the community with the skills required to care from them utilising the Best Practice Standards in EOL care

This will be achieved as follows;

- Provision of short-term nursing care and rehabilitation for individuals who are unlikely to require diagnostic facilities (care home beds) but cannot be managed in their home environment.

- Focused on those in need of a nursing home or community hub bed as those suitable for residential care settings are likely to be deemed fit enough to receive care at home with community care.

For:

- Patients who are not in need of 24-hour access to consultant-led medical care;

- Patients who require non-specialist rehabilitation or reablement from a multidisciplinary/ multiagency team e.g. wrap around community in reach model of rehabilitation, who are competent in the management of multiple co-morbidities, long term conditions, and the frail elderly;

- Patients who require 24-hour access to nursing care or support at the end of life

- Patients whose short-term needs can be addressed within a limited period of time e.g. 4 days for step up and 24 days for step down care as part of their overall care pathway or an agreed timescale for end of life care

- Patients who do not require large scale diagnostics such as specialist x-ray or scans. NB. These patients would be able to access ambulatory care services as required.

Principles

- Admission is based on individualised holistic assessment of nursing and therapeutic need as opposed to alleviating and overcoming delays for community care services.

- Admission is based on an active need for short term nursing, rehabilitation and/or medical oversight and medicines management as opposed to respite care.

- Admission criteria include those whose needs are deemed too unpredictable to rely on scheduled home visits

- Primary focus of interventions is on support to maintain independence and prevent acute exacerbation of illness with emphasis on older people and long-term conditions (e.g. Early intervention and use of bed ('step-up') for complex, multi-morbidity patients to prevent unnecessary admission to acute hospital setting) and 'step-down' care and rehabilitation to support patients as they return home from an acute hospital admission.

- The commissioned Community bed availability is matched to the needs of a defined geographical area/community.

- End of Life care shall be provided for all patients approaching the end of their lives being cared for in the community including short term care beds ensuring patient choice is promoted and facilitated, adhering to the principles and standards of Best Practice in EOL care

and working in partnership with the patient, their family and all other relevant professionals to ensure a holistic approach.

- A person centred approach will be undertaken at all times which means that joint care and support plans for patients will be developed with the patient and their family/relative/carer that have achievable outcomes identified and agreed with the customer.

- A multi-disciplinary approach to care and rehabilitation.

Standards for Community Short term Beds

NB. The standards are aligned to Community Hospital service standards

- Integrated care, treatment and discharge records held on SystmOne, utilising and promoting the use of the Dorset Anticipatory Care Plan (DACP)

- Admission and discharge 7 days a week with admissions being made by 5pm and discharges by 12.00 midday

- Next day admission will be acceptable if the referral is received after 3pm

- Agreed admission criteria to be set

- Adherence to the Principles and Standards of Best Practice in EOL care

- Patients will be treated according to their agreed Dorset Anticipatory Care Plan and full assessment be completed within 24 hours of admission.

- Agreed treatment plan and achievable goals set prior to admission and reviewed within 24 hours of admission

- Estimated Discharge Date will be set at initial assessment, to be reviewed and adjusted at weekly MDTs as necessary

- Consistent application and use of comprehensive geriatric assessment prior to admission by staff qualified to do so.

- Daily review, by a competent health care professional from the multidisciplinary team 7 days a week to include; a short and focussed daily multidisciplinary board round including a senior clinician from the in reach wrap around team; GP, senior nurse practitioner or a senior therapist, the nurse in charge/ senior care home staff and other representatives from the allied healthcare professional team as appropriate to check patients' progress against their respective goals, with the aim of removing any barriers to discharge and managing internal waits.

- The length of stay should be appropriate to an individual's needs in the context that the EDD should be tailored to the patient's condition and treatment goals.

- Agreed expected date of discharge (EDD) is set by a senior clinical decision maker (GP/Geriatrician/Advanced Nurse Practitioner/in reach wrap around team member) within 14 hours of admission. To be agreed with the patient, family and carers.

- Nurse and therapy led discharge planning based on achievement of jointly agreed treatment goals.

- Discharge and onward care and treatment plans should be formulated around the achievement of clear treatment goals linked to an individual's level of functional independence and physiological wellbeing.

- Care providers, including relatives, must be involved in and made aware of discharge plans.

- The care home/community hub staff will be involved in discharge arrangements – providing feedback on the person's progress and attending weekly review meetings.

- The wrap around community in reach Rehabilitation, Nursing team and social care team (including support from the care home) will work together to make all arrangements to ensure a safe discharge, including:
  - Equipment
  - Medication/dressings/etc.
  - Care arrangements – if required
  - Onward referral to appropriate agencies as required
  - A holistic care plan

Provider role and responsibilities

It is expected that the provider will support the philosophy of rehabilitation, reablement and EOL care promoting the independence of the customer to lead the life they wish and reducing their dependency on support packages through the use of a reabling approach and to support patients at end of life in accordance with the principles and standards of Best Practice in EOL care ensuring that the patient and their families, relatives or carers:

- Are fully aware of the purpose of their placement, has agreed the outcomes and are committed to returning home after an agreed period of rehabilitation or reablement

- Are fully aware of the purpose of their placement and are able to accommodate the wishes of the patient at the end of life

- Are supported to return home following their stay in a Rehabilitation and Reablement bed.

- Are made to feel welcome during their short stay.

- Will be able to take part in any of the care home activities.

- Will have the opportunity to engage in conversation with staff and other residents. Will be recognised as a contributor to the delivery of their own joint Care and Support Plan e.g. DACP
- Will identify their outcomes or by Best Interest Decision Making should the customer be unable to identify their chosen outcomes themselves.
- Are recognised that they are able (with capacity) to make their own choices and decisions regarding risk with the support and advice of others where required

The provider will;

- Inform the locality hub single point of access of the decision to accept a patient (or not) within 1 hour of receiving the referral.
- Accept admissions seven days a week, from 10am until 5pm.
- Provide 24-hour care
- Provide a named Rehabilitation and Reablement lead within the care home (from existing staff)
- Temporarily register each patient with the appropriate GP Practice if required
- If medical care is required out of hours, the Care Home/community hub will contact the out of hours' medical service
- Provide access to secure Wi-Fi to enable the visiting therapists and social care staff to work efficiently.
- Allow therapists and social care staff to input into the care home's records – documenting visits and updating care plans.
- Follow the care plans as produced by the community in reach multidisciplinary team in order to progress the patients abilities
- Be committed to the development and retention of staff, ensuring that the provider has appropriate numbers of staff who are trained and skilled to provide the services defined in this document.
- Implement the Mental Capacity Act 2005, including Deprivation of Liberty Safeguards, with appropriate use of mental capacity assessments and best interest decision making
- Manage challenging and difficult behaviour
- Identify, support and work with carers
- Use a reabling and rehabilitative approach to service delivery
- Implement the principles and standards of Best Practice in EOL care
- Inform the multidisciplinary team on the day of:
  - Admission – confirming the person's safe arrival

- Discharge – including Hospital admissions and Deaths

- Provide access to an appropriate room for the weekly multi-disciplinary team meetings.
- Provide access to an appropriate room where therapists and social care staff can complete their documentation, with secure Wi-Fi access.
- Provide access to a suitable rehabilitation area including stairs and basic kitchen facilities to enable patients to continue their rehabilitation

Equipment

- Provide appropriate standard equipment required by the customer whilst resident in the Rehabilitation, Reablement or End of Life bed
- If an individual Customer has specialist equipment needs prior to placement, the discharging acute ward or admitting community team must ensure that the necessary specialist equipment has been commissioned and is available prior to placement.
- Available equipment must include standard pressure care mattresses, a range of chairs of different heights and depths and walking aids to maximise the comfort and independent mobility of patients plus standard equipment for end of life care.

Continence products

- As patients admitted to rehabilitation, reablement and end of life care home beds are temporary residents of the care home, the care provider is not expected to provide continence products to these patients. However, it is the responsibility of the provider to ensure a prompt continence assessment is conducted and products prescribed as necessary.
- If the patient has undergone a continence assessment and receives prescription continence pads, family/carers are expected to provide the care homes with the products from the patient's own supply.
- If the patient has not had a continence assessment, the community in reach and nursing team will assess if the patient requires a continence assessment and request a referral for an assessment, if appropriate. In the meantime, the family/carers are expected to provide continence pads until the patient is in receipt of prescription continence pads (if that is the outcome of the assessment).

Pathway

Patients can be admitted to a community short term bed for a period of Rehabilitation and Reablement Care from an acute hospital (step down) or community setting (step up).

Referral process to 'step up' care beds

Step up: The service shall manage acute events for patients which previously led to a hospital admission e.g. urinary tract infection, acute episode of falling or confusion. Nursing care provided by the care home will be supplemented by an Advanced Nurse Practitioner with prescribing rights.

Rehabilitation and Reablement beds may also be used as a contingency for patients who have returned from hospital to home, with support from health and social care but this support cannot be sustained (for example as a result of environmental factors, equipment needs within the home or unable to maintain the customers safety).

Pathway

- Referral received by Locality Integrated Care Hub (single point of contact).
- Rapid response assessment appointment/telephone call by senior clinical decision maker (GP/Geriatrician/Advanced Nurse Practitioner) within 2 hours of receipt of referral by Locality Hub
- Agreed criteria met for admission to community care home bed for a defined period of rehabilitation or Reablement
- Treatment plan agreed with the patient, their carers', in reach community rehabilitation team and the receiving organisation prior to admission and uploaded to SystmOne NB. Patients are likely to be unstable and may require onward referral for acute care therefore clear pathways, processes and procedures need to be in place at a service level and individual (individual care plan) level.

Referral process to 'step down' beds

- Step down: the provider shall facilitate timely discharge from bed-based services to the individual's place of origin wherever possible with the support of an Advanced Nurse Practitioner and the community in reach wrap around rehabilitation team. The provider shall manage patients proactively with an expected date of discharge.
- Acute hospitals will adopt the principle of 'discharge to assess'. This means that the patient will be confirmed as medically stable, and able to leave the care of an acute hospital, but there will be a specific reason why they cannot return to their own home, for continuing rehabilitation or reablement.

Pathway

- Locality Integrated Care Hub (single point of contact) aware of all acute admissions from Locality and receives daily handover of progress and EDD
- Referral received through Locality Integrated Care Hub (single point of contact).
- Agreed criteria met for admission to community care home Rehabilitation and Reablement bed
- Treatment plan agreed with patient, their carers', community in reach rehabilitation team and receiving organisation, prior to admission, and uploaded onto SystmOne.

Referral process to 'end of life' care within community short term beds

- Admittance to a short term bed is in accordance with the patient's wishes as recorded in their DACP The admittance process is as per the step up and step down

Workforce

Roles and Responsibilities of the MDT rehabilitation and reablement wrap around community in reach team;

Senior Clinical Decision Maker (Specialty Doctor/GP Extensivist/Advanced Nurse Practitioner)

- Provide medical support and leadership within the Locality Integrated Care Hub Multidisciplinary Team (including the community in reach team) in managing elderly, complex and vulnerable patients at home, in a community hub bed or in a community care home rehabilitation and reablement bed.
- Liaise with the wider Team to avoid admissions, facilitate discharge of patients and assesses for admission to step up community care home beds.
- Provide medical cover and/or advanced nursing skills to patients at home, in a community hub bed or in a community care home rehabilitation and reablement bed as required within the locality
- Link closely with locality GPs, in management elderly, complex and vulnerable patients
- Link closely with medical staff in Secondary Care

Nurse

- Community nurses with appropriate skills and competencies to recognise the deteriorating patient
- Provide training in nursing care to care home staff e.g. pressure area relief, promotion of continence, nutrition and hydration

Occupational Therapist

- Lead on Rehabilitation for tasks of daily living
- Provide psychological support
- Advise on home and minor adaptations and equipment

Physiotherapist

- Lead on Rehabilitation and restoration of strength and mobility
- Transfers, walking and stairs training

Rehabilitation Support Workers

- To support the patient in achieving their goals as agreed with patient, carers and rehabilitation and Reablement staff

Pharmacist/Technician

- Provide medicines reviews, advice and optimise medicines management

Dietician

- Provide dietary review and advice

Speech and Language Therapist

- Provide review, rehabilitation and advice on swallowing and speech difficulties

Social worker

- Assess and support on-going care needs

Case Management

The in-reach wrap around community team will provide the overarching Case Management, with support from the Provider's Lead Nurse. This is especially important where patients are admitted outside of the reach of their community in reach team.

Multi-disciplinary meetings

Each Care home providing Rehabilitation and

Reablement beds will have a weekly Multi-disciplinary meeting, which will include:

- Care Home's lead nurse (or deputy)
- Identified GP
- Physiotherapist
- Occupational therapist
- Social worker

Risk management

It is expected that the care home provider will inform the Intermediate Care team of any issues which occur, including issues with:

- Admissions
- Complaints
- Accidents/incidents
- Problems with discharges

Training

There will be time when additional training is made available via the Community In-Reach wrap around Team. Care home staff are expected to participate with this training. Care homes will be given adequate notice in order to plan staffing support and attendance.

Key Performance Indicators

The Contractor shall monitor the occupancy and usage of the beds and shall review the numbers of beds commissioned on an annual basis with the CCG to ensure that the capacity is matched to demand. Such monitoring shall include the frequency with which beds are not available when required.

KPI	Definition	Reporting Period	Tracked & Reported By	Minimum Standard
Patients are accepted 7 days a week	Admissions are not affected by the day of the week.	Monthly	Provider	100%
Patients are admitted within 48 hours of request being received for step down bed	Admissions are made in a timely manner	Monthly	Provider	100%
Patients are **accepted** between the hours of 10am – 7pm	To understand the trend/identify the pattern of admission times.	Monthly	Provider	100%
Patients arrive before 7pm	To understand the proportion of patients arriving before 17:00	Monthly	Provider	80%
A comprehensive assessment is made within 24 hours	Patients changing needs are identified and EDD set	6 Monthly at contract review		100%
Care home staff training undertaken on nursing skills, moving and handling, rehabilitation and end of life care	That care home staff have attended training sessions as provided by the In-Reach Community team	6 Monthly at contract review		80%
Rooms within a care home are identified as Rehabilitation and Reablement, EOL	That the Rehabilitation and Reablement rooms are clearly identified as such and situated in	6 monthly – at contract review	Provider	95%

care within a defined area	one area EOL care			
Number of issues experienced with admissions into beds e.g. time of arrival, delayed discharge	To identify and improve areas of issue.	6-monthly	Provider	
All patients have a named care manager that the patient and family are aware of	Patients and their family/carers have a named point of contact	Monthly	Provider	100%
All patients have a DACP or end of life care plan started or continued	All patients receive an initial review at the beginning of their episode	Monthly	Provider	100%

Outcomes

Outcomes will be measured in line with the Integrated Community Services dashboard.

Typical patient scenarios where use of community hospital and community beds is appropriate:

(Level of acuity and complexity would determine type of community bed e.g. hospital or care home)

- A person who has had a fractured neck of femur and subsequently contracted a urinary tract infection (UTI), or patients deemed too unstable to return home/clinical rehabilitation cannot be provided at home.
- A direct admission into the community bed for ongoing treatment and healthcare for an acute illness as part of a crisis care plan e.g. those with limited carers at home who have an intravenous treatment requirement alongside other clinical needs.
- A person needing palliative & terminal care where there is a defined clinical need (medical, psychological and/or social) preventing them from remaining at home and they do not require specialist in-patient palliative care.
- A person with a previously agreed community advanced care plan which makes admission to an acute or community hospital bed inappropriate or unnecessary.

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Glossary of Terms

Admission

Depending on circumstances, a patient can be admitted (to hospital) as:

- A day patient (day case) – patient given a hospital bed for tests or surgery but will not stay overnight. This can include treatments such as minor surgery, dialysis or chemotherapy
- An inpatient – patient will stay in hospital for one night or more for tests, medical treatment or surgery.
- An outpatient – patient attends hospital for an appointment but does not stay overnight

(NHS Choices)

Advance Care Planning (end of life care)

Advance Care planning is key means of improving care for people nearing the end of life and of enabling better planning and provision of care, to help them live and die in the place and the manner of their choosing. The main goal in delivering good end of life care is to be able to clarify peoples' wishes, needs and preferences and deliver care to meet these needs. It is a structured discussion with patients and their families or carers about their wishes and thoughts for the future. http://www.goldstandardsframework.org.uk/advance-care-planning

Anticipatory Care Planning

A process of discussion between an individual, their care providers, and often those close to them, about future care.

Comprehensive Geriatric Assessment (CGA)

A multidimensional assessment, treatment plan and regular review delivered by a multidisciplinary team. Although commonly conducted in hospital setting, there is evidence that provision of CGA to people with frailty in community settings could reduce hospital admissions.

Discharge plan

Once a patient is admitted to hospital, their treatment plan, including details for discharge or transfer, should be developed and discussed with them. A discharge assessment and plan will determine whether a patient will need more care after leaving hospital. The patient should be fully involved in the assessment process.

Frailty

A distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves. Around 10% of people aged over 65 years will be living with frailty and for those people a minor event can frequently trigger major health changes or deterioration and therefore it is important to recognise and identify these changes early. (British Geriatric Society)

MDT (Multi-Disciplinary Team)

A multidisciplinary team (MDT) is composed of members from different healthcare professions with specialised skills and expertise. The members collaborate together to make treatment recommendations that facilitate quality patient care
https://definitions.uslegal.com/m/multidisciplinary-team-mdt-health-care/

A multidisciplinary approach involves drawing appropriately from multiple disciplines to explore problems outside of normal boundaries and reach solutions based on a new understanding of complex situations. Multidisciplinary working involves appropriately utilising knowledge, skills and best practice from multiple disciplines and across service provider boundaries, e.g. health, social care or voluntary and private sector providers to redefine, re-scope and reframe health and social care delivery issues and reach solutions based on an improved collective understanding of complex patient needs. NHS England: MDT Development – Working toward an effective multidisciplinary/multiagency team: 7 January 2014

Mental Capacity/Mental Capacity Assessments

The Mental Capacity Act (2005) states that a person lacks capacity if they are unable to make a specific decision, at a specific time, because of an impairment of, or disturbance, in the functioning of mind or brain. You may need to assess capacity where a person is unable to make a particular decision at a particular time because their mind or brain is affected by illness of disability. Lack of capacity may not be a permanent condition. Assessments of capacity should be time- and decision-specific. You cannot decide that someone lacks capacity based upon age, appearance, condition or behaviour alone. Every effort should be made to find ways of communicating with someone before deciding that they lack capacity to make a decision based solely on their inability to communicate. Also, you will need to involve family, friends, carers or other professionals. Under the MCA, you are required to make an assessment of capacity before carrying out any care or treatment – the more serious the decision, the more formal the assessment of capacity needs to be. (Social Care Institute for Excellence)

http://www.scie.org.uk/publications/mca/assessing-capacity/

Minor surgery

Any surgical operation of short duration and minimal risk. Most minor surgery is performed under local anaesthesia. Collins Dictionary of Medicine

Prevention at scale

The Prevention at Scale programme will help people to stay healthy and avoid getting unwell. Prevention is not a new idea, but with more people developing long term conditions our approach to prevention is now as much about promoting health and well-being as it is about preventing disease. We are committed to working in partnership to tackle the wider determinants of health – the complex and often interrelated factors that influence people's mental and physical wellbeing, and in the longer-term impact on their health and care needs. Our programme also aims to help individuals take control of their own wellbeing and make healthy choices that will keep them well for longer. As we plan and deliver services we will consider what effects we can have on the health of all our population. (Dorset Sustainability and Transformation Plan)

Primary care

Primary care is often the first point of contact for people in need of healthcare, and may be provided by professionals such as GPs, dentists and pharmacists.

Reablement

Providing personal care, help with daily living activities and other practical tasks, usually for up to six weeks, reablement encourages service users to develop the confidence and skills to carry out these activities themselves and continue to live at home. (www.communitycare.co.uk/2010/09/20/what-is-reablement)

Rehabilitation

To help somebody to return to good health or a normal life by providing training or therapy (Encarta dictionary)

Risk Stratification

Used to identify people with highly complex, multiple morbidity and/or frailty (and their carers), who might benefit from multi-disciplinary team support as part of case management and care planning;

• to identify and target specific service needs of patient groups, (e.g. for people with diabetes in order to improve their quality of care, experience of care and clinical outcomes);

• to identify suitable patients for the caseload of specialist nursing or medical services such as community geriatricians, community matrons or mental health practitioners for example, or for end of life advance care planning, use of the Electronic Palliative Care Co-ordination System (EPaCCS); or to reduce unnecessary unplanned admissions. https://www.england.nhs.uk/wp-content/uploads/2015/01/2015-01-20-CFRS-v0.14-FINAL.pdf

Secondary care

Secondary care, which is sometimes referred to as 'hospital care', can either be planned (elective) care such as a cataract operation, or urgent and emergency care such as treatment for a fracture

Specialty Doctor

Specialty Doctors are doctors and dentists who generally work within one specialty, invariably in secondary care, under the supervision of one or more Consultants. (BMA definition).

Unplanned care

Urgent and emergency healthcare which is not a programmed (scheduled) activity

UTI

Urinary Tract Infection: Infections of the bladder (cystitis) or urethra (tube that carries urine out of the body) are known as lower UTIs. Infections of the kidneys or ureters (tubes connecting the kidneys to the bladder) are known as upper UTIs. UTIs occur when the urinary tract becomes infected, usually by bacteria. In most cases, bacteria from the gut enter the urinary tract through the urethra. (NHS Choices)