Classification: Official

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COVID-19 EPRR Community Daily Discharge SitRep

Technical Specification

Version 4

29 September 2022

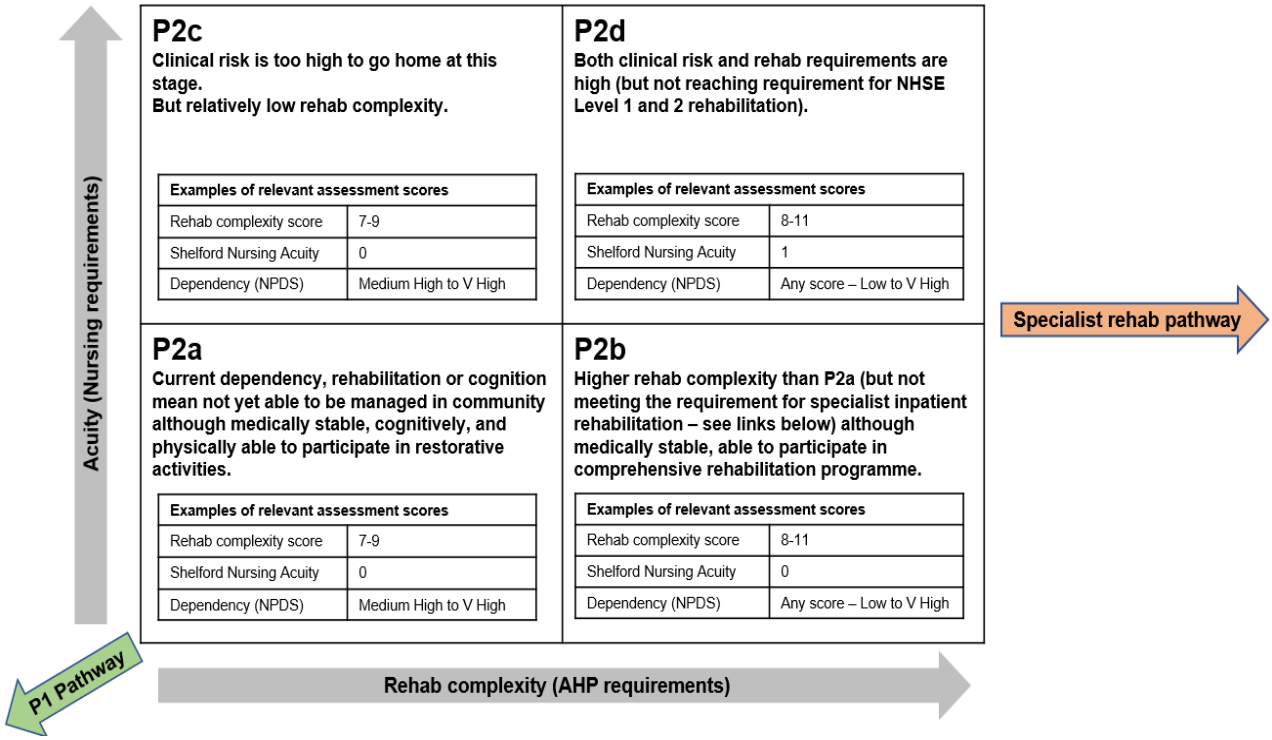
Introduction

This is a revised version of previous guidance (April 2022) relating to the Covid-19 EPRR Community Daily Discharge SitRep, to reflect changes to this data collection highlighted in yellow.

The following changes have been made:

- Question 1 has been amended with revised Criteria to Reside categories more closely aligned with the needs of patients residing in non-specialist community beds.

'The number of patients who meet the criteria to reside in total, and split by the number falling into the following reasons to reside categories:'



Key:

- Level 1 & 2 Rehabilitation
- Rehab complexity score extended (RCS-E)
- Shelford Nursing Acuity
- Dependency (NPDS)

- Question 2 has been amended to capture details of patients who are residing in P2 beds who do not meet the revised Criteria to Reside categories now in

question 1. Please note an additional category has been added to cover requirements relating to infection prevention and control guidance.

'The number of patients who do not meet the criteria to reside that day split by the following categories:'

P2i delay	P2ii delay	P2iii delay
Suitable for discharge via Pathway 1 but residing in P2 due to lack of P1 capacity.	Suitable for discharge via another pathway or route but residing in P2 due to other reasons (e.g. awaiting P3 care or specialist capacity).	Residing in P2 due to infection control policy (e.g. COVID-19).

- Questions 3 and 4 have been amended to remove data collection items for the number of people discharged by 17:00 hours, so they now only include data collection items for the number of people discharged by 23:59.

  This amendment is to reduce the burden of data collection for community providers. People on all pathways should still be discharged from community settings as early in the day as possible, ideally before 5pm, as agreed with people and their family members/carers and any providers of onward care and support.

- Question 4 has been amended to stipulate patients not meeting the criteria to reside and were discharged that day.

- Question 4: the pathway categories have been developed to include hotel or temporary accommodation along with Hospice at Home and support for reablement, rehabilitation or end of life.

- Questions 5 and 6 have been reordered so that question 5 now asks for the total number of people who have length of stay of 14 days and over and question 6 asks for the total number of people who have a length of stay of 21 days and over.

Context

FAQs have been updated and are available on the NHS Futures platform (Community Daily Discharge SitRep FAQs).

It is important this is a clinically driven data collection.

This is an important data collection, the outputs of which are regularly reviewed by local, regional and national teams and your returns are helping to drive the effective implementation of wider Hospital Discharge guidance and post-discharge care, and is flowing into the national capacity and demand tool to support system planning and commissioning. It will lead to better care for patients and service users by increasing understanding of discharge practices, the use of pathways, and demand and capacity availability. Thank you for your ongoing support in helping us to collect accurate and timely information.

Discharge and Community Cell
Primary, Community & Personalised Care Directorate
NHS England

Background

The Community daily discharge situation report (SitRep) commenced on 22nd June 2020 and collects data on the inpatient population of Community Hospital Bed Providers and their discharge status each day using the SDCS portal.

This guide outlines how to complete the SitRep and associated revised content.

Submission process

The submission template will need to be populated by all the organisations listed as providing NHS commissioned bedded services within the community for the purposes of physical health recovery and rehabilitation. This will include:

- NHS Community Trusts
- Acute Trusts that also provide community services which include community hospitals (with only their community hospital beds covered by this data collection).
- Mental Health Trusts that provide physical health community services which include community hospitals (with only their community hospital beds covered by this data collection).
- Community Interest Companies and others who provide physical health community services and community hospitals beds.
- Care Homes where physical health recovery and rehabilitation services are provided in 10 or more beds.

Please note that, in order to avoid double counting, organisations should not submit data on behalf of any other Providers – those Providers will now be submitting their own data directly.
If you are aware of a provider that you believe is in scope (as defined under 'Background') of the collection please send their details through to: england.communityhealthservicesdata@nhs.net.

Weekly reports must be signed off by a duty director, or other senior manager, appointed to this role by the Provider's chief executive. It is the responsibility of each

Trust to ensure its return is accurate and reflects the real position for the relevant time period.

Seven days of data should be provided for questions 1 to 4:

- Question 1 is calculated as the sum of 1a) to 1d).
- Question 2 is calculated as the sum of 2a) to 2c).
- Question 3 will be automatically populated as the sum of the numbers submitted for the different sub-categories under question 4.

Question 5 and 6 should be collected as a weekly snapshot on any day of the week, as long as the day is consistent each week.
Submission of responses to all questions need to take place via the online portal before 12:00 hours every Monday and there will be no opportunity to amend the data once submitted.

Guidance notes on data items

The full, revised set of questions for this data collection are reproduced below, with commentary in bold. Updated Frequently Asked Questions can be found on the NHS Futures platform: Community Daily Discharge SitRep FAQs

Contacts and resources

Please direct queries relating to this collection to:
england.communityhealthservicesdata@nhs.net

All webinar recordings and useful documents can be found on the NHS Futures platform.

An Excel workbook has been produced to assist Providers to complete this data return, and an updated improved version of this will be supplied to nominated SitRep leads within providers. The Excel workbook has been carefully designed to quickly fill in at the morning and afternoon board rounds under the guidance of clinicians, in order to keep the burden of collecting this important data to a minimum (though Providers can use other systems they may already have in place – the use of the Excel workbook is not mandatory).

SitRep Questions

1) The number of patients who meet the criteria to reside in total, and split by the number falling into the following reasons to reside categories:

    a) P2a: Current dependency, rehabilitation or cognition mean not yet able to be managed in community although medically stable, cognitively, and physically able to participate in restorative activities.

    b) P2b: Higher rehab complexity than P2a (but not meeting the requirement for specialist inpatient rehabilitation – see links in key above) although medically stable, able to participate in comprehensive rehabilitation program.

    c) P2c: Clinical risk is too high to go home at this stage. But relatively low rehab complexity.

    d) P2d: Both clinical risk and rehab requirements are high (but not meeting the requirement for specialist inpatient rehabilitation).

    Data for this question should be collected daily. This is a **mandatory field,** which must be completed.

2) The number of patients who do not meet the criteria to reside that day split by the following categories:

    a) P2i delay: Suitable for discharge via Pathway 1 but residing in P2 due to lack of P1 capacity.

    b) P2ii delay: Suitable for discharge via another pathway or route but residing in P2 due to other reasons (e.g., awaiting P3 care or specialist capacity).

    c) P2iii delay: Residing in P2 due to infection control policy (e.g., Covid 19).

Data for this question should be collected daily.

This is a **mandatory field**, which must be completed.

3) Of the total number of people who do not meet the criteria to reside that day, the number of patients who were discharged by 23:59 hours that day.

Data for this question should be collected daily.

This is a **mandatory field**, which must be completed.

4) Of the patients who did not meet the criteria to reside and were discharged that day, the number of patients discharged by 23:59 to the following locations:

NOTE: letters in the green shaded boxes in the table correspond to the full definitions below. Black boxes represent out of scope combinations of care pathway and physical discharge location.

	Domestic Home or setting	Hotel or other temporary accommodation	Hospice or Hospice at Home (Pathway 1)	Community Rehab bed	Care Home	Bed based setting (e.g. homeless hostel or Extra Care facility)
Pathway 0 - Home/Hotel /Other - No new support needed from health and social care	**a**	**b**				
Pathway 1 - Home/Hotel /Other - New support for reablement, rehab, end of life care	**c**	**d**	**e**			

Pathway 2 - not usual residence - rehab / short-term care in 24-hour bed-based setting - for hospices includes end of life patients		**f**	**g**	**h**	**i**
Pathway 3 - admission or return to a care home which is likely to be permanent				**j / k**	

a) Pathway 0 – Discharge to a domestic home. No new care or support needed from health and social care once home.

b) Pathway 0 – Discharge to a hotel or other temporary accommodation. No new care or support needed from health and social care once home.

c) Pathway 1 – Discharge to a domestic home or setting. New care or support needed from health and social care services for reablement or rehabilitation.

d) Pathway 1 – Discharge to a hotel or other temporary accommodation. New care or support needed from health and social care services for reablement or rehabilitation.

e) Pathway 1 – Discharge to a Hospice at Home. New care or support needed for reablement, rehabilitation or end of life.

f) Pathway 2 – Discharge to a Hospice. For short term 24 hour bedded including end of life support.

g) Pathway 2 – Discharge to a Community Rehabilitation Bed. For rehabilitation or short-term care in a 24-hour bed-based setting before return home.

h) Pathway 2 – Discharge to a Care Home Bed. For rehabilitation or reablement short-term temporary care in a 24-hour bed-based setting before return home.

i) Pathway 2 – Discharge to a bed-based setting e.g. homeless hostel or Extra Care facility. For rehabilitation or short-term temporary care in 24-hour bed-based setting before return home.

j) Pathway 3 – Discharge as a new admission to a Care Home which is likely to be permanent.

k) Pathway 3 – Existing Care Home resident discharged back to a Care Home.

Data for this question should be collected daily.

This is a **mandatory field**, which must be completed.

5) Of the total number of people who have a length of stay of 14 days and over and who have been assessed as not meeting the criteria to reside:

a. The number of additional days in total they have remained in hospital since not meeting the criteria to reside decision was made.

b. A breakdown showing the number of people against each of the following reasons for why they continue to remain in a non-specialist community bed, despite not meeting the criteria to reside.

i. Awaiting a medical decision/intervention including writing the discharge summary.

ii. Awaiting a therapy decision/intervention to proceed with discharge, including writing onward referrals, equipment ordering.

iii. Awaiting referral to community Transfer of Care Hub or receiving service.

iv. Awaiting medicines to take home.

v. Awaiting transport.

vi. Awaiting confirmation from community Transfer of Care Hub or receiving service that referral received and actioned. (The community Transfer of Care Hub should make the decision on which pathway will best meet the needs as described by the therapists).

vii. Pathway 1: awaiting availability of resource for assessment and start of care at home.

viii. Pathway 2: awaiting availability of rehabilitation bed in community hospital or other bedded setting.

ix. Pathway 3: awaiting availability of a bed in a residential or nursing home that is likely to be a permanent placement.

x. Awaiting community equipment and adaptations to housing.

xi. Individual/family not in agreement with discharge plans.

xii. Homeless/no right of recourse to public funds/no place to discharge to.

xiii. Safeguarding concern preventing discharge or Court of Protection.

xiv. Awaiting transfer back to an acute Trust.

xv. No plan.

xvi. Awaiting diagnostic test.

xvii. Remains in non-specialist Community bed to avoid spread of infectious disease and because there is no other suitable location to discharge to.

xviii. Awaiting outcome of decision for CHC funding.

Data for this question should reflect a weekly 'snapshot' of the status on a single day of the reporting period. The weekday chosen for the snapshot is at the discretion of submitters but should be a consistent day every week (i.e. every Wednesday). The data for the weekly snapshot day is still uploaded with the rest of that submission period's daily data by 12:00hrs each Monday.

6) Of the total number of people who have a length of stay of 21 days and over and who have been assessed as not meeting the criteria to reside:

a. The number of additional days in total they have remained in hospital since not meeting the criteria to reside decision was made.

b. A breakdown showing the number of people against each of the following reasons for why they continue to remain in a non-specialist Community bed, despite not meeting the criteria to reside.

i. Awaiting a medical decision/intervention including writing the discharge summary.

ii. Awaiting a therapy decision/intervention to proceed with discharge, including writing onward referrals, equipment ordering.
iii. Awaiting referral to community Transfer of Care Hub or receiving service.
iv. Awaiting medicines to take home.
v. Awaiting transport.
vi. Awaiting confirmation from community Transfer of Care Hub or receiving service that referral received and actioned. (The community Transfer of Care Hub should make the decision on which pathway will best meet the needs as described by the therapists).
vii. Pathway 1: awaiting availability of resource for assessment and start of care at home.
viii. Pathway 2: awaiting availability of rehabilitation bed in community hospital or other bedded setting.
ix. Pathway 3: awaiting availability of a bed in a residential or nursing home that is likely to be a permanent placement.
x. Awaiting community equipment and adaptations to housing.
xi. Individual/family not in agreement with discharge plans.
xii. Homeless/no right of recourse to public funds/no place to discharge to.
xiii. Safeguarding concern preventing discharge or Court of Protection.
xiv. Awaiting transfer back to an acute Trust.
xv. No plan.
xvi. Awaiting diagnostic test.
xvii. Remains in non-specialist Community bed to avoid spread of infectious disease and because there is no other suitable location to discharge to.
xviii. Awaiting outcome of decision for CHC funding.

Data for this question should reflect a weekly 'snapshot' of the status on a single day of the reporting period. The weekday chosen for the snapshot is at the discretion of submitters but should be a consistent day every

week (i.e. every Wednesday). The data for the weekly snapshot day is still uploaded with the rest of that submission period's daily data by 12:00hrs each Monday.