COVID-19 emergency preparedness, resilience and response (EPRR) community daily discharge sitrep

Technical specification

Version 5, October 2023

Statement on reducing health inequalities

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and technical guidance defined in this document we have given a recommendation for local systems to capture intermediate care and reported outcomes for people with frailty and complex needs, in addition to capturing information on those who might be homeless and in temporary accommodation.

Publication reference: PRN00683_ii

Contents

Background and context

The Community daily discharge situation report (sitrep) commenced on 22 June 2020 as part of the Covid-19 national response. It collects daily data on the inpatient population of community bed providers and their discharge status using the Strategic Data Collection Service (SDCS) portal, with a weekly section relating to discharge delay reasons.

There have been four updates since the Community daily discharge sitrep was first set up and this latest update has been made in response to a policy change which implements a new programme of intermediate care (as per the Delivery plan for recovering urgent and emergency care services).

Intermediate care is provided via a 'step-down' referral route which aims to help people learn or re-learn skills, recover from illness/injury, manage long-term conditions, improve confidence, and maximise independence.

This involves community-based assessments and time-limited interventions provided to people in their usual place of residence (home-based) or in bed-based settings.

This guide outlines the question updates and provides instruction on how to complete the SitRep with associated revised content.

Why is data so important?

The accurate collection, recording and reporting of data is critically important for ensuring that people are benefitting from effective intermediate care services and will support:

- health and social care commissioners and providers to understand how responsive their local services are, which will lead to improvements in patient experience and outcomes
- alignment with the intermediate care framework
- learning and continuous quality improvement
- identifying gaps in capacity and capability which may be affecting consistent delivery of the standards
- onward discharge from intermediate care services.

Submission process

In scope

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

- NHS and jointly commissioned community beds
- 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 (CIC) and others who provide physical health community services and community hospitals beds
- care homes where physical health recovery and rehabilitation services are provided
- all block contracted and spot purchase beds in the above categories.

NB. The challenges of submitting data for smaller providers is acknowledged (for example, less than 10 beds) and where this is the case it is suggested that integrated care boards (ICBs) complete the return on behalf of those providers.

Please note, to avoid double counting, provider organisations should not submit data on behalf of any other providers. Submission on behalf of providers should only take place when ICBs are required to submit on behalf of their smaller providers – as noted above.

If you are aware of a provider that you believe is in scope of the collection, please send their details (name and email address of responsible person) to england.nhsdata@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 community provider 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) but may not match the total in question 1
- question 3a is calculated as the sum of 3b i) to iii)
- question 4a is calculated as the sum of the pathways within question 4b.

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

Explanatory notes on the updated questions are below. This is followed by the full and revised set of questions for this data collection. Changes to the questions are highlighted in yellow to be easily identifiable.

Updated frequently asked questions (FAQs) can be found on the FutureNHS Collaboration Platform (login required).

To request access to the platform, please email england.intermediatecare@nhs.net

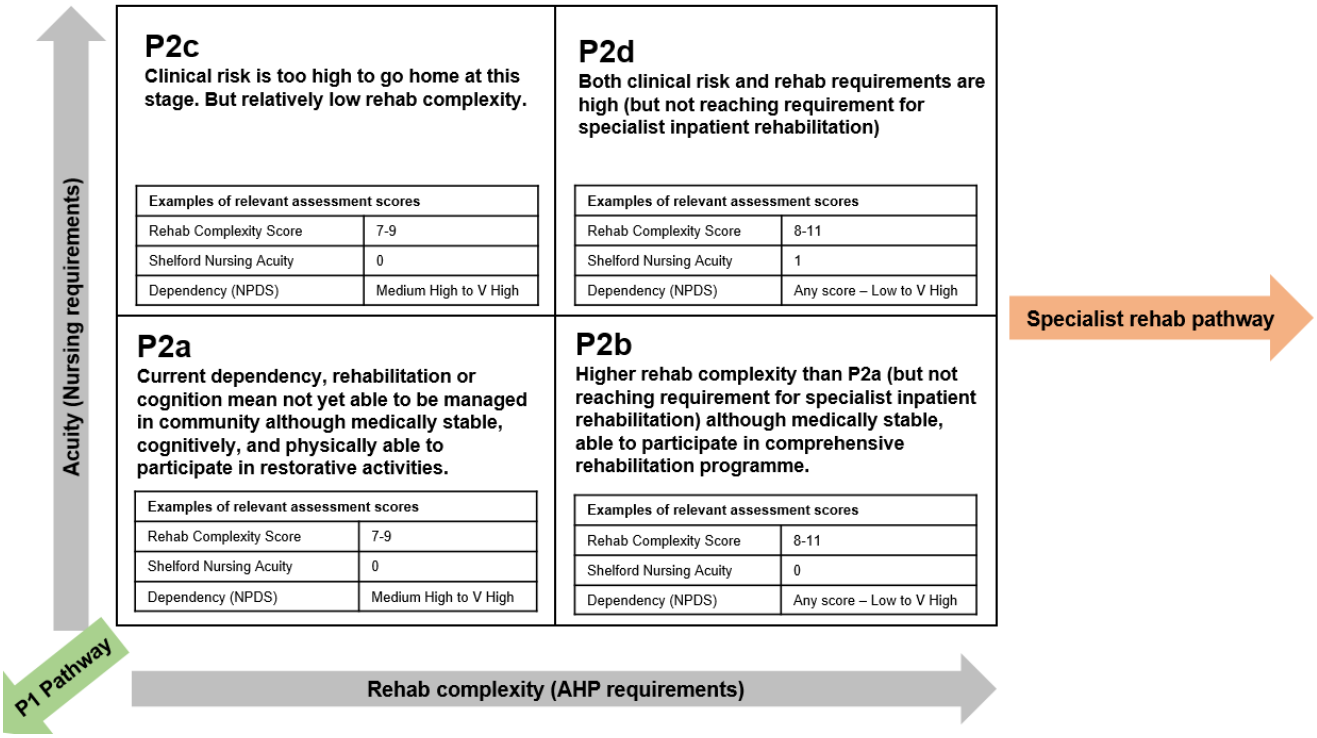
Updated questions

Explanatory notes

All references to ‘patients’ have been changed to ‘people’ to align with the Intermediate care framework for rehabilitation, reablement and recovery following hospital discharge. discharge.

- **Question 1:**
  - Minor changes to improve clarity.
  - Aligns with the rehabilitation needs-based sub-categories. For further guidance see Optimising bed and home based rehabilitation, reablement and recovery services toolkit v2.
  - P2a to P2d (inclusive) should amount to the total number of people in the beds who meet the criteria to reside as explained in the rehab complexity table below:

Rehab complexity table



Key:

- Specialist inpatient rehabilitation
- Rehabilitation complexity scale: extended (version 13)
- Shelford safer nursing tool
- Dependency (NPDS)

- **Question 2: NEW question**
  - Rationale – will show gaps in service provision and distribution between the

three categories and will provide granularity on numbers of people receiving rehabilitation, reablement and recovery services and numbers waiting for assessment and/or services to start.

  - Linked to question 1 as it relates to people who meet the criteria to reside.
  - Some people may not fit into any of the three options for this question. The sum of the 2a) to 2c) (inclusive) may not amount to the total number of people meeting the criteria to reside but the sum of question 2 cannot be greater than the sum of question 1.

- **Question 3:**
  - Minor changes to improve clarity.
  - Question 3a and 3b, previously question 2, is the total of 3b i-iii plus the total of discharges in question 4a. This is calculated automatically from the totals of 3b i-iii and the pathways within question 4b.
  - Rationale: to identify people who are in a pathway 2 bed and do not meet the criteria to reside because their care needs would be best met elsewhere. This could be due to a lack of capacity (for example, pathway 1) or other reasons.
  - Question updated to simplify and remove the word ‘delay’ as this is covered in questions 5 and 6.
- **Question 4a:**
  - Minor changes to improve clarity.
  - Previously question 3.
  - 4a is calculated automatically from the totals of the pathways within question 4b.
- **Question 4b:**
  - Previously question 4.
  - Three additional options added (previously eleven options, now fourteen).
  - Two of the categories which previously captured ‘discharge to a nursing home

bed' and 'discharge to a community bed,' have been merged. They are now captured in (j) as 'discharge to another pathway 2 bed' to reduce burden.

- Introduction of 'rehabilitation, reablement and recovery' terminology to capture intermediate care activity.
- Terminology updated to differentiate between those people being discharged from a community bed to a continuation of their rehabilitation, reablement and recovery service in a different setting (for example, home/hospice/another community bed), and those who are being discharged from rehabilitation, reablement and recovery services with a longer-term package of care to meet their needs.

- **Questions 5 and 6:**
  - Snapshot – completed weekly. Capturing delays for those people who have a length of stay of 14 days and over and 21 days and over.
  - Some small wording changes have been made, including incorporating intermediate care terminology – rehabilitation, reablement and recovery - and changing the name from 'transfer of care' hubs to 'care transfer hubs' to align with forthcoming policy.
  - Small additional changes have been made to support question clarity and interpretation.
  - vii reference to assessment has been removed as the question is only required to capture resource availability; the assessment should have been completed.
  - xiv additional wording added following provider feedback.
  - There are two new delay categories:
    - viii pathway 1: awaiting availability of resource for continuation of rehabilitation, reablement and recovery at home. This has been added to capture delays in continuation of intermediate care services when a person is able to continue their intermediate care at home.

- xi pathway 3: awaiting availability of a bed in a residential or nursing home for end of life care. Added following provider feedback.

Questions (updated)

1) The number of people who meet the criteria to reside in total, 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 a domestic home or setting 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) although medically stable, and actively participating in a comprehensive rehabilitation programme.

c) P2c: Clinical risk is too high to go to a domestic home or setting at this stage. Relatively low rehabilitation complexity.

d) P2d: Both clinical risk and rehabilitation 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.

[NEW]

2) Of those identified as meeting the criteria to reside in question 1, the number in total split by the following categories:

a) The number receiving rehabilitation, reablement and recovery services.

b) The number assessed and waiting for rehabilitation, reablement and recovery services.

c) The number who have not yet been assessed for their rehabilitation, reablement and recovery needs.

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

3a) The number of people who do not meet the criteria to reside.

b) Of those who do not meet the criteria to reside, the number in total split by the following categories:

i) P2i ~~delay~~: Suitable for pathway 1 but residing in pathway 2 due to lack of pathway 1 capacity.

ii) P2ii ~~delay~~: Suitable for another pathway or route but residing in pathway 2 due to other reasons (for example, awaiting pathway 3 care or specialist capacity).

iii) P2iii ~~delay~~: Residing in pathway 2 due to infection control policy (for example, Covid-19).

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

4a) Of the total number of people who did not meet the criteria to reside that day, the number of people who were discharged by 23:59 hours.

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

4b) Of the people who did not meet the criteria to reside and were discharged that day, the number of people 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 at home	Hospice	Another pathway 2 bed	Bed-based setting (for example, homeless hostel or other extra care facility)	Care home
Pathway 0 **- no new support needed from health and social care**	a	b					
Pathway 1 **- new support needed from health and social care for rehabilitation, reablement and recovery, end of life care and long-term care needs**	c/d	e/f	g/h				
Pathway 2 **- <u>not</u> usual residence** **- 24-hour bed-based setting** **- rehabilitation, reablement and recovery** **- hospice for end of life care**				i	j	k	
Pathway 3 **- admission or return to a care home which is likely to be permanent** **-admission for end-of-life care**							l/m/n

-readmission to original care home placement	

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 to continue with rehabilitation, reablement and recovery.

d) Pathway 1 – Discharge to a domestic home or setting with a new care package to manage ongoing, long term care needs.

e) Pathway 1 – Discharge to a hotel or other temporary accommodation to continue with rehabilitation, reablement and recovery.

f) Pathway 1 – Discharge to a hotel or other temporary accommodation with a new care package to manage ongoing, long-term care needs.

g) Pathway 1 – Discharge to hospice at home to continue with rehabilitation, reablement and recovery and end of life care.

h) Pathway 1 – Discharge to hospice at home for end-of-life care.

i) Pathway 2 – Discharge to a hospice for end-of-life care.

j) Pathway 2 – Discharge to another pathway 2 bed to continue with rehabilitation, reablement and recovery.

k) Pathway 2 – Discharge to a homeless hostel or extra care facility to continue with rehabilitation, reablement and recovery.

l) Pathway 3 – Discharge as a new admission to a care home which is likely to be permanent.

m) Pathway 3 – Discharge from rehabilitation, reablement and recovery services as a new admission to a care home for end-of-life care.

n) Pathway 3 – Discharge back to original care home placement when the care home has confirmed they can continue to meet the person's needs.

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 a community bed 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 care transfer hub or receiving service.

iv. Awaiting medicines to take home.

v. Awaiting transport.

vi. Awaiting confirmation from care transfer hub or receiving service that referral received and actioned.

vii. Pathway 1: awaiting availability of resource for start of care at home (not a continuation of rehabilitation, reablement and recovery).

viii. Pathway 1: awaiting availability of resource for continuation of rehabilitation, reablement and recovery at home.

ix. Pathway 2: awaiting availability of another rehabilitation, reablement and recovery bed in a community bedded setting.

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

xi. Pathway 3: awaiting availability of a bed in a residential or nursing home for end-of-life care.

xii. Awaiting ~~community~~ equipment and/or adaptations to housing.

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

xiv. Homeless/no right of recourse to public funds/no place to discharge to/lack of housing offers when previous residence no longer suitable.

xv. Safeguarding concern or Court of Protection preventing discharge.

xvi. Awaiting ~~transfer back~~ readmission to an acute trust.

xvii. No plan.

xviii.Awaiting diagnostic test.

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

xx. Awaiting outcome of decision for continuing healthcare 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 a community bed 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 a care transfer hub or receiving service.

iv. Awaiting medicines to take home.

v. Awaiting transport.

vi. Awaiting confirmation from a care transfer hub or receiving service that referral received and actioned.

vii. Pathway 1: awaiting availability of resource for start of care at home (not a continuation of rehabilitation, reablement and recovery).

viii. Pathway 1: Awaiting availability of resource for continuation of rehabilitation, reablement and recovery at home.

ix. Pathway 2: awaiting availability of another rehabilitation, reablement and recovery bed in a community bedded setting.

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

xi. Pathway 3: awaiting availability of a bed in a residential or nursing home for end-of-life care.

xii. Awaiting ~~community~~ equipment and/or adaptations to housing.

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

xiv. Homeless/no right of recourse to public funds/no place to discharge to/lack of housing offers when previous residence no longer suitable.

xv. Safeguarding concern or Court of Protection preventing discharge.

xvi. Awaiting ~~transfer back~~ readmission to an acute trust.

xvii. No plan.

xviii. Awaiting diagnostic test.

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

xx. Awaiting outcome of decision for continuing healthcare 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.

Definitions

NHS data dictionary

The information in this section should be considered in conjunction with the NHS Data Dictionary.

Intermediate care:

- **Step-down intermediate care:** time-limited, short-term (typically no longer than 6 weeks) health and/or social care provided to adults (aged 18 years or over) who need support after discharge from acute inpatient settings and virtual wards to help them rehabilitate, re-able and recover.
- **Rehabilitation:** includes therapy-led reablement interventions to support people to recover and retain function.

Recording and reporting the data

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).

- The full technical specification for the Community discharge sitrep is published on the NHS England website.
- Guidance on registering on the NHS National Data Platform (Foundry) onboarding guide - NHS National Data Platform - FutureNHS Collaboration Platform (login required).
- For access to Tableau, system leads should email the Analytical Products team england.analyticsproductsteam@nhs.net
- The Community daily discharge sitrep data is published weekly at: https://www.england.nhs.uk/statistics/statistical-work-areas/discharge-delays-community-data/

Contacts and resources

Contacts

For submission queries: england.nhsdata@nhs.net

For policy related queries: england.intermediatecare@nhs.net

Resources

Updated frequently asked questions can be found on the Future NHS platform: Community Daily Discharge Situation Report (SitRep) - Intermediate Care Programme (login required).

All webinar recordings and useful documents can be found on the Future NHS platform: Community of Practice for Community Providers - Intermediate Care Programme (login required).

The Intermediate care planning framework for rehabilitation, reablement and recovery following hospital discharge is available on the NHS England website.