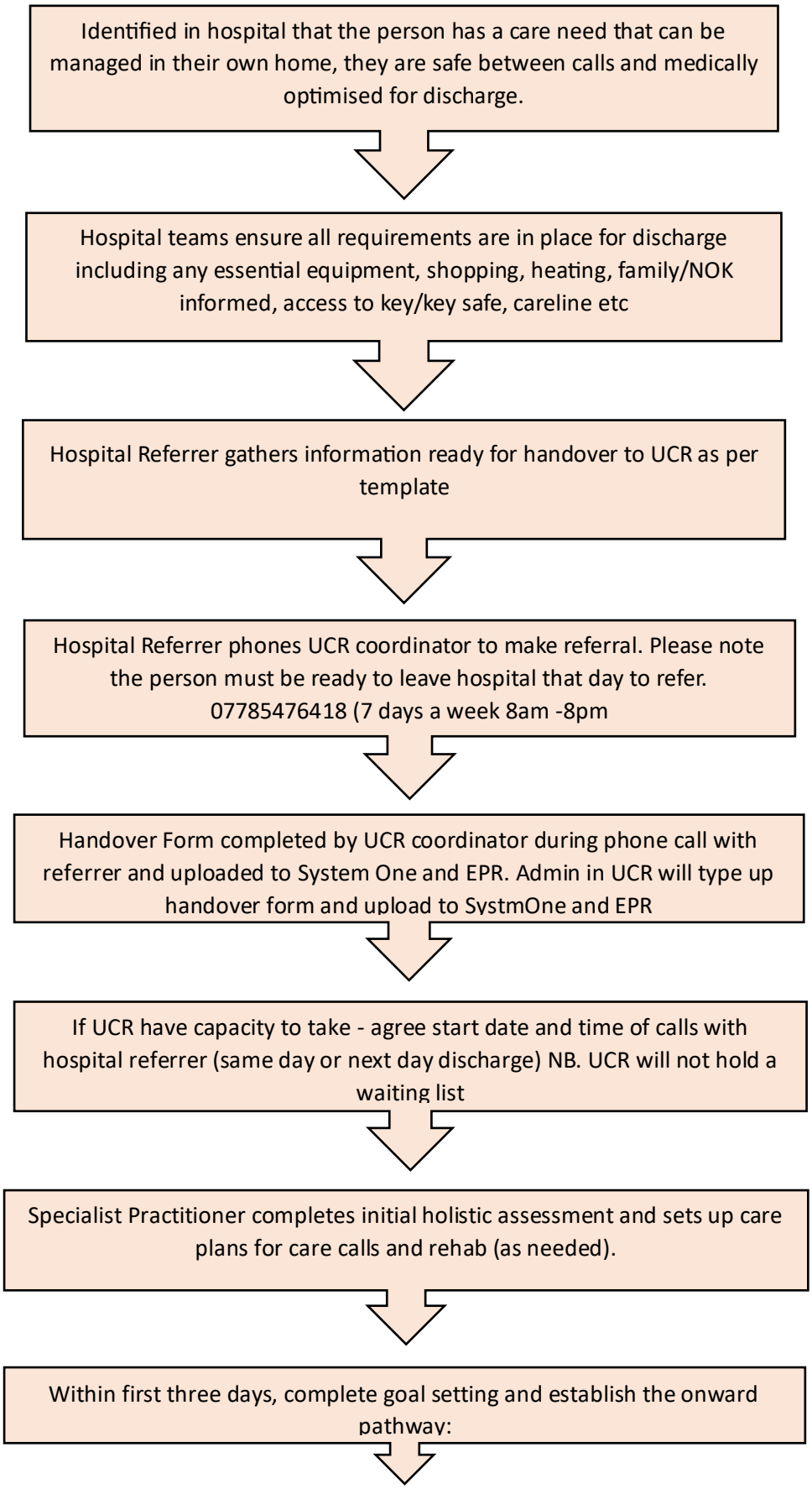
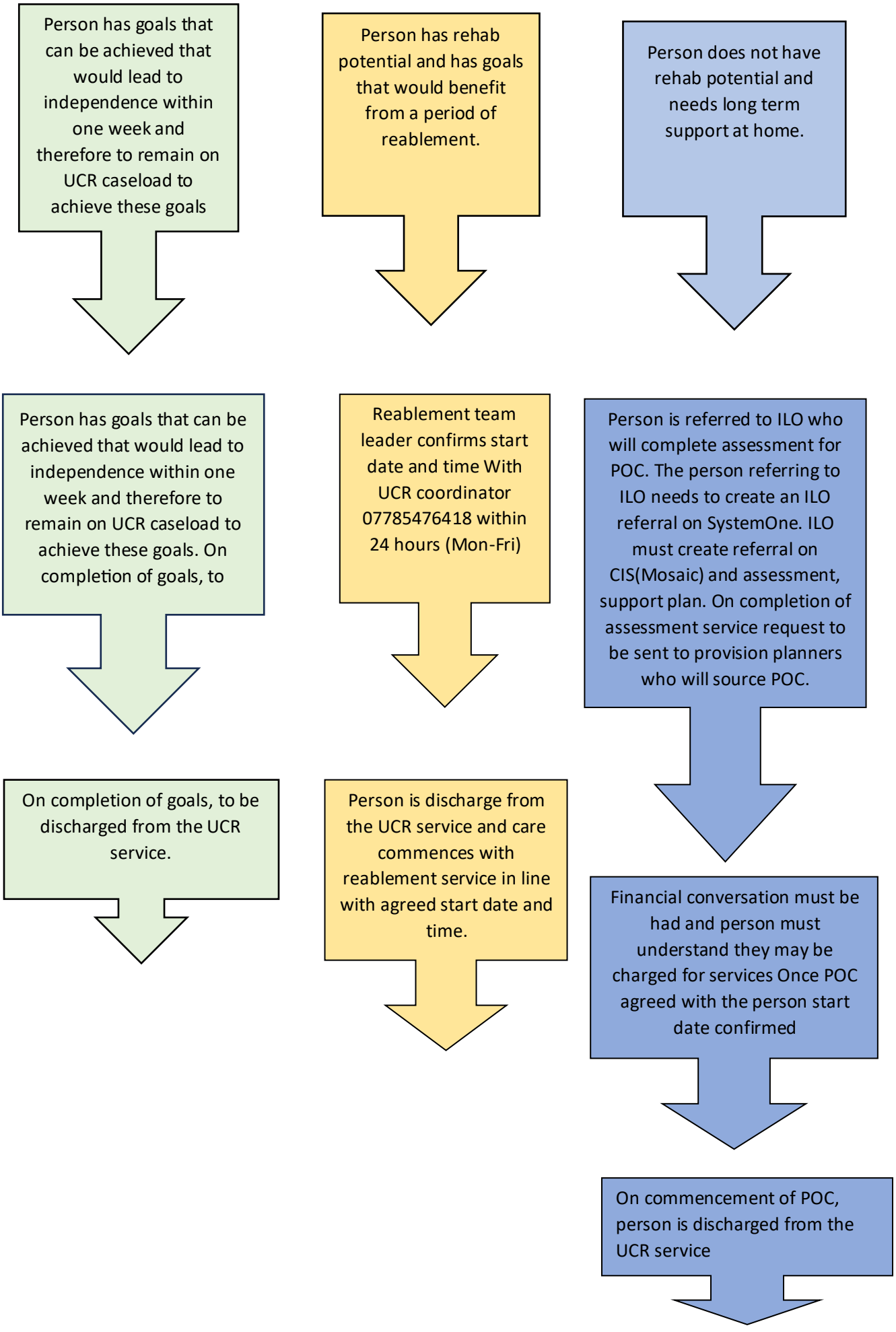
Adult Services and Wellbeing
Calderdale Metropolitan Borough Council

People's Pathway – Pathway 1 (Hospital)


Identified in hospital that the person has a care need that can be managed in their own home, they are safe between calls and medically optimised for discharge.
Hospital teams ensure all requirements are in place for discharge including any essential equipment, shopping, heating, family/NOK informed, access to key/key safe, careline etc
Hospital Referrer gathers information ready for handover to UCR as per template
Hospital Referrer phones UCR coordinator to make referral. Please note the person must be ready to leave hospital that day to refer. 07785476418 (7 days a week 8am -8pm
Handover Form completed by UCR coordinator during phone call with referrer and uploaded to System One and EPR. Admin in UCR will type up handover form and upload to SystmOne and EPR
If UCR have capacity to take - agree start date and time of calls with hospital referrer (same day or next day discharge) NB. UCR will not hold a waiting list
Specialist Practitioner completes initial holistic assessment and sets up care plans for care calls and rehab (as needed).
Within first three days, complete goal setting and establish the onward pathway:


Person has goals that can be achieved that would lead to independence within one week and therefore to remain on UCR caseload to achieve these goals
Person has rehab potential and has goals that would benefit from a period of reablement.
Person does not have rehab potential and needs long term support at home.
Person has goals that can be achieved that would lead to independence within one week and therefore to remain on UCR caseload to achieve these goals. On completion of goals, to
Reablement team leader confirms start date and time With UCR coordinator 07785476418 within 24 hours (Mon-Fri)
Person is referred to ILO who will complete assessment for POC. The person referring to ILO needs to create an ILO referral on SystemOne. ILO must create referral on CIS(Mosaic) and assessment, support plan. On completion of assessment service request to be sent to provision planners who will source POC.
On completion of goals, to be discharged from the UCR service.
Person is discharge from the UCR service and care commences with reablement service in line with agreed start date and time.
Financial conversation must be had and person must understand they may be charged for services Once POC agreed with the person start date confirmed
On commencement of POC, person is discharged from the UCR service