GP Training & Education Event

Discharge to Assess Programme

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Why now? Benefits to primary care, the system and your patients

Why now?

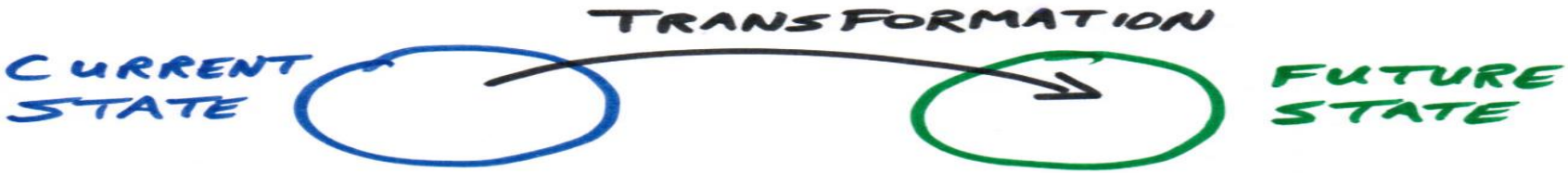
Ageing population; need to minimise DToCs and improve flow; need for multi-agency collaboration for smooth patient pathway; need for discharge to the right environment with the right support; nationally mandated; the need for system & staff culture change

Benefits for patients:

- The right care and support, in the right place, at the right time for patients
- Improved access to therapeutic interventions (particularly upon discharge from IHT)
- Higher quality of support, less generic discharge,
- More robust post acute care for the patient's needs

Benefits for primary care & the system:

- Continued ability to step patients up into community beds
- Clear referral pathways and easier access to the right services
- Improved flow from IHT to help provide winter resilience
- Shared risks
- Shared resources
- System improvements



The Ipswich Hospital NHS Trust

Suffolk County Council

Suffolk Community Healthcare

NHS Ipswich and East Suffolk Clinical Commissioning Group

IHUG Ipswich Hospital User Group

The Ipswich Hospital Charity. Caring since 1995. Registered charity number 1048827

Integrated Model of Care

Patient No Longer Has Care Needs That Can Only Be Met in Hospital

Pathway 0	Pathway 1	Pathway 2	Pathway 3
No complex needs, no reablement/ rehab needs	Needs can safely be met at home, further rehab/ reablement needed	Not safe to return home, further rehab / reablement needed	Not safe to return home, currently limited or no potential to benefit from rehab
Restart any existing care or support package, refer to voluntary sector if needed	Up to 6 week package of rehabilitation and/or reablement at home. May be review after 2 weeks if reablement not appropriate to move to Pathway 0/2/3	Rehabilitation in community bed. Weekly review of progress. CHC assessment if appropriate	Rehabilitation/care in community bed. Weekly review to consider move to Pathway 0/1/2. Specialist input as needed. CHC assessment if appropriate
	After 6 weeks		
Review as normal for ongoing needs	Review, decide to extend 6 week period or move to Pathway 0/2/3. Assess for long term health and care needs	Review, decide to extend 6 week period or move to Pathway 0/1/3. Assess for long term health and care needs	Review long term health and care needs

Ticket Home

British Red Cross

REABLEMENT
#GetUpAndGo

Shared Risks

Shared Resources

Bluebird Lodge – with new focus as STARR centre

- Short Term Assessment Reablement & Rehabilitation Centre
- Will provide RAPID (up to 14 days) bed-based, rehab & reablement for patient optimisation
- This form of rehab will bring significant benefit to patients and flow within the system (plan is 60 patients per month)
- Aim to launch by November 2017, helping to provide winter resilience

Note: only part of pathway two – does not include specialist longer term rehab