# Change 5: Discharge to assess and effective intermediate care

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| Stage | Not yet established | Plans in place | Established | Mature | | Exemplary |
| **Discharge to assess** | People are usually assessed for care on an acute hospital ward | Plans have been drawn up for a discharge to assess pathway, and bedded capacity in the community is being created to do complex assessments outside of acute hospital wards | Discharge to assess pathway implemented, and practice changes in place to increase the number of complex assessments in the community | | Whenever possible, people are supported to be assessed in their usual place of residence | Assessments under the Care Act, continuing health care, and mental health capacity take place in people’s own homes unless a short period of step down reablement is needed. Investment in joint community-based reablement delivers increased independence and increased flow through hospital |
| **Reablement and pathways** | Long-term care decisions are routinely made in an acute hospital ward. People are entering residential/nursing care too early. The reablement service is not effective in reducing people’s needs and/or has severely limited capacity. | Existing pathways have been evaluated and solutions developed for shifting the focus to reablement and recovery. Capacity is being created for reablement and other home-based intermediate care. Focus is being made on how ensure target increase in people’s independence. | Practice changes in place to make reablement and recovery the norm. Reablement service uses SMART goal setting most of the time and has mostly effective multi-disciplinary teams to maximise independence. | | Decisions about long-term care are not made in acute hospital wards, but instead after people have accessed reablement, or other home-based intermediate care services. Wherever possible, people return home with reablement/intermediate support. Most people accessing reablement have SMART goals that are reviewed at least once in MDTs. Information on progress towards plans and actions is tracked and reviewed. | Investment in joint community based reablement delivers increased independence and increases flow through hospital. Single points of access ensure clarity of pathways and equality of access. Everyone accessing reablement has SMART goals that are regularly reviewed in MDTs. Information on progress towards plans and actions is tracked and reviewed. There is specialist input in the support for people in the service. |
| **Intermediate beds and pathways** | Long-term care decisions are routinely made in an acute hospital ward. People are entering residential/nursing care too early. There is no or little provision of intermediate beds, people sent to short-term beds receive little rehabilitation, reablement and recovery | There are plans in place to create the appropriate capacity for intermediate beds. These are short-term beds in community bedded settings with dedicated rehabilitation, reablement and recovery. | There is appropriate capacity of intermediate care beds. There is a culture and focus on reablement and rehabilitation, leading to a large proportion of people returning home after the period in an intermediate bed. | | Most people discharged to intermediate beds have SMART goals that are reviewed in MDT. There is input from health, therapy and social work professionals to ensure maximum independence. Once a person is ready to return home, they are able to continue their reablement journey. Plans are in place to develop intermediate provision to meet a range of needs, some specialist. | Everyone discharged to intermediate beds has SMART goals that are regularly reviewed in effective MDT meetings. There is input from health, therapy and social work professionals to ensure maximum independence. Once a person is ready to return home, they are able to continue their reablement journey. There exists intermediate provision to meet a range of needs, including specialist provision. |