
DRAFT
PREVENTION
INTERVENTION
Healthy Lifestyle
Home Environment
Falls Prevention
Early Diagnosis (Dementia)
'High Risk' Co-ordination
EOL Package
5
Acute
Patients
Enhanced geriatrician input at admission to Shorten Lengths Of Stay
Identifying high risk patients at discharge
Early Supported Discharge (Stroke Dementia)
Specialist Beds (#NOF)
Acute Infections
Early Mobilisation
Mental Health (Specialist Beds)
Support for Carers
Support for Domiciliary Care
Nursing Home Case Management
Navigation Case Management
Diagnostics
EOL Package
4
Sub Acute Patients
(0 – 5 days LOS)
Step Up Beds (Not residential/Nursing Homes)
Community Geriatrician (cohort seen in outpatients in 1st week)
Reablement & Rehabilitation (Community Care Teams)
Front Door Assessment (Community Orientated)
Diagnostics
SPA
Telecare / Telehealth
Carer Support
Names GP with Care Plan
Community Care Team
(MDT) Meeting
3
Multiple Long Term Conditions
(Same Day)
Medically stable &
treated in the community
STARR (Step Down) emphases on rehab & reablement
Outpatient Assessment
Combined Geriatrician Clinics &
Co Morbidity Clinics
Virtual Wards
Community Care Teams (MDT) Visits
Diagnostics
Specialist Mental
Health Input
EOL Register
& Pathways
Education
Information & Advice
Portal
Navigation
2
Primary Care
Medically stable and
ambulatory
Walk In Centres (triage)
A&E (triage)
Pharmacy
Voluntary Sector
Education
Information & Advice
Portal
Navigation
1
Healthy Ageing
Walk In Centres
A&E
Pharmacy
Voluntary Sector
NEW
Step Up Beds
Discharge To Assess
Medvivo Pilot
Community Geriatrician Service Specification
A&E Assessment Unit (RACE / Dart)
HSD for Stroke, Dementia, Mental Health
PROJECTS
Enhanced
STARR (Step Down beds)
EMI Beds
HTLAH
SPA / RR
Community Ward Specification
Diagnostics
Community Care Teams inc. Community Co-ordinators