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**Community Health Services in Tower Hamlets**
***Supporting discharge from hospital***

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**The Admission Avoidance & Discharge Services (AADS)**

The AADS is an integrated service which combines the following functions:-

- Admission avoidance in ED with follow up in AAU and/or the community (7 days per week in ED from 8am to 7pm)
- Hospital at home for medically optimised patients who need increased nursing / therapy support (e.g. for 2 weeks) to support prompt discharge from hospital (7 days per week from 8am to 6pm)
- In-reach nursing team who work between wards and community health teams to facilitate discharge for patients with complex needs (7 days per week from 8am to 6pm)
- Home support pathway or discharge assess, which enables patients to be discharged home for assessment of care needs with additional health & social care packages in place. This pathway includes providing CHC assessment in a person's home where appropriate. (7 days per week from 8am to 6pm)

The AADS team includes nurses, occupational therapists, physiotherapists and social workers. The team is made up of both permanent and temporary employees due to the nature of the funding arrangements currently in place with the CCG.

The AADS aims to:

- Avoid unnecessary admissions for patients who attend the Emergency Department
- Improve the transfer of care from the Royal London Hospital to community services
- Facilitate discharge for patients who are expected to become clinically stable in the next 1-2 days and can be safely managed by community nurses with advanced clinical skills
- Support patients who require further health/therapy assessments to go home as soon as they are medically stable
- Support patients who require short term rehabilitation to return to their previous level of function

Identifying patients for the AADS starts in the Emergency Department with patients identified by the admission avoidance team who can be safely discharged home and followed up in the community by therapies or other members of multi-disciplinary team (MDT). It will not always be possible to discharge all patients home and where this is the case, the AADS team follow the patient into the hospital ensuring that there discharge back home is planned from point of admission.

Patients are identified from the wards by the in-patient therapy teams, who make direct referrals to AADS as well as by the nurse screeners who form part of the AADS team. The nurse screeners as well as the in-reach team work directly with wards to case find and identify patients suitable for the home support pathway. The nurse screeners & in-reach teams will also refer cases to CHC assessors where appropriate. The in-reach team attend daily board rounds on RLH, with their main focus being on the 11th, 13th & 14th floor, to enable them to work with ward teams to support the prompt discharge of patients home and identify additional cases for AADS. Clinical dialogue will take place if patients are already known to the CHTS/ specialist teams to ensure the right person sees the patient to support discharge.

A member of the AADS team also attends the RLH daily safety huddle and at least one of the thrice daily capacity meetings to ensure all patients who will benefits from the AADS service are identified and referred to the team.

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Patient attends RLH Emergency Department between 8am-7pm and is identified for AAT input (by case finding or ED staff referral)

AAT assess patient and advise whether s/he is able to be discharged home

Patient discharged home

Patient assessed by AAT in ED/CDU and admitted to RLH

Patient in hospital not previously known to AADS and:

- Is suitable for discharge to assess model or
- Needs intensive rehabilitation or
- Will become medically stable in 1-2 days and suitable for AADS nursing
- Needs short-term IV antibiotics

Ward staff call DEC phone 45898 to make referral
(or IV phone 07507894927 for community IV antibiotics)

If community follow up is required:

-AAT alert CHT or

- if not known and requiring therapy input, contact patient to arrange AADS follow up visit within 24 hours

- Initial Assessment template completed and AAT therapy staff hand over to AAU therapists the same day/following morning to assist with discharge planning
- If transferred to other ward, AAT call therapy staff to hand over
- In-reach nurses attend board rounds daily and track progress
- In-reach nurses inform AADS screener if patient still suitable for community input or not medically stable
- **OR** Ward staff call DEC phone 45898 to make new referral

**AADS staff liaise with CHC staff.**

**If a patient has a positive checklist and is able to be supported at home then can be discharged home with AADs support.**

**Checklist will be re done by CHC at 4 weeks / DST as appropriate**

- Screener takes information over phone/ goes to ward to review patient if required (all nursing patients) - within 2 hours if same day discharge, if not medically stable/ready for discharge then within 48 hours
- Patient is accepted for AADs or referral rejected and reasons provided
- Once accepted, screener follows up daily until medically stable/discharge date confirmed
- Screener/In-reach nurses take proactive approach to facilitating discharge as soon as medically stable/optimised
- Once discharge date is known, AADS visit offered same or next day (depending on time patient leaves hospital)
- AADS community staff (including social worker) meet every morning at 9am to allocate new patient visits
- Screener calls community staff member if need for urgent visit identified after allocation meeting

**Community Health Teams (CHT)**

Community Health Teams are multi-disciplinary teams of Nurses, Occupational Therapists, Physiotherapists, Care Navigators, Social workers, Psychologists and access to additional health care professionals. Services operate 24 hours a day, 7 days a week for nursing. The community nursing team focus on nursing interventions which are not specifically related to rehabilitation but have a strong emphasis on self-management.
Referral to the services is via the Single Point of Access.

**CHT Therapy Physiotherapy and Occupational Therapy Rehabilitation Service:**

The therapy service within CHT are mainly focused on rehabilitation and working towards a person's individual goals. A thorough home based assessment will be carried out by a fully trained health care professional and a treatment plan tailored from the assessment findings. Various strategies will be employed to assist a patient in attaining their goals which will include use of functional rehabilitation, home based exercises, provision of appropriate equipment etc. All interventions will be discussed with the patient in advance and aim to work towards their personal goals.

The therapy service provides short term intervention with a strong focus on self-management and continued improvement once therapy provision from CHT has stopped. The therapists within CHT will work with patients suffering from a variety of medical conditions and complaints. The following are examples of common reasons for referral to the therapy service:

- Falls
- Balance impairments
- Fractured Hips (traumatic)
- Pre-habilitation (preparation of patients for elective orthopaedic surgery)
- Musculo-skeletal complaints for those who are housebound
- Post admission rehabilitation
- BPPV
- Difficulty in managing activities of daily living e.g: difficulty with managing meal preparation
- Cognitive Rehabilitation

*Referral Pathway and referral triage process:*

Referral to the CHT therapy team is received from varying health care professionals. All new referrals are submitted to the Single Point of access. Here the referral is registered and placed in the correct locality in accordance to patient's GP and address demographics. All new referrals are screened and triaged by integrated locality team members daily. Each new referral is prioritised and placed into the correct therapy service.

CHT therapy team have a priority criterion as follows:

Rapid Response (2 hrs)

Immediate assessment and intervention (needs based contact within 2 hours) to keep the person at home if safe and possible to do so, or facilitate a safe discharge

- Sudden deterioration (within the past 24 hrs) in the community with immediate high risk of admission
- Facilitation of discharge from ED of hospital (i.e. non-admitted patients) whereby patient is at high risk of readmission (within 24 hours)
- Palliative care – to enable dying at home
- Urgent Response (24 hrs) Needs based contact within 24hrs for assessment and intervention as required to facilitate safe and timely discharge home from hospital or prevent an admission to hospital
- Breakdown of urgent equipment (if not covered by CES)

- Client / carer at high risk of injury due to manual handling
- Acute chest infection / aspiration. Client at risk of admission and requires assistance with secretion clearance (must have already been seen by medic within 24 hours and commenced on antibiotics)
- High falls risk e.g. recurrent (2 or more) within past 5 days. Not presented to other health services.
- Replacement walking aid for indoor mobility required (not known to CES)
- Non routine post-surgical e.g. Total Hip Replacement assessment / intervention to decrease risk of dislocation
- High risk of readmission of palliative care client

Routine Care (5 days)

- Facilitate safe and timely discharge home from hospital or prevent an admission to hospital / long term placement
- Palliative care at risk of readmission or to facilitate discharge / carer advice
- Assessment of client who has not received an assessment from another CHT clinician / HSW / Lead Care Navigator within 5 days of referral
- Falls risk
- Post-op intervention for orthopaedic surgery with risk of deterioration or readmission
- Significant high level of risk in carrying out essential care and daily living tasks
- Manual Handling issues for carers
- High risk of pressure area breakdown & needing MDT input

Non urgent Rehabilitation (3weeks) (which may include long-term rehab client with on-going potential)

- Post-op intervention for progression of function with no risk of readmission or deterioration
- Progression of mobility aid with no risk of readmission or deterioration
- Outdoor mobility and community access
- Patients who are reprioritised following, for example, psych input and are therefore ready for treatment
- Client has on-going rehab needs but is able to maintain function
- Long-term chronic pain
- Vocational rehabilitation

Hours of service:

The therapy team operates from 08.30hrs – 17.00hrs Monday- Friday and 09.00hrs - 17.00hrs Saturday and Sunday.

**Elderly Care Rehabilitation Services**

Elderly care rehabilitation services are based at Mile End Hospital. There is one elderly care rehabilitation ward (24 beds) which is supported by a multi-disciplinary team of nurses, doctors and therapists.

Criteria for admission to the ward is over 65, accepted under the care of the elderly care consultants at the Royal London.

Patients will have on going rehabilitation needs or complex discharge needs eg anxiety or 3 to transfer. Patients can stay for up to 42 days but average length of stay is much shorter- last year average length of stay was 11.2 days.

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**Specialist Rehabilitation Services**

Barts Health runs some specialist rehabilitation services that support patients who have been discharged from hospital following a specific condition related episode. These teams are:-

- Stroke Rehab for patients after an acute stroke.
- Cardiac rehab and heart failure services.
- Adult Community Neuro Team for patients with acute, chronic and progressive neurological conditions.
- Adult Community Respiratory Team (ArCare) for patients with chronic lung disease and patients with heart failure.

These specialist services: aim to provide timely high quality care for patients and their families/ carers who have been diagnosed with a long term condition or had an acute episode of care. The focus is on early intervention and assessment in the community, involving a range of health care professionals with specialist knowledge. The services provide a multi-disciplinary holistic assessment. They work as an integrated part of the team with secondary care Consultants and ward staff to facilitate early supported discharge. They provide admission avoidance and anticipatory care in the community by case management and care co-ordination, aiming to minimize risk, complications and to manage changing conditions. They provide on-going goal orientated rehabilitation within community settings

The teams include occupational therapists, physiotherapists, specialist nurses, speech and language therapists, psychologists, support workers, care navigators, dietician's physiologists and administration staff. The services aim to meet the physical and psychological needs of the individuals and their support network.

The services run with varying hours for each team but across 7 days. Referrals are taken directly from the ward, from AADs , from the CHTs or via SPA.