Accelerated Discharge Policy

ELFT Community Health Newham, Barts Healthcare NHS Trust - Newham General Hospital, London Borough of Newham Adult Services

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Version Control Summary

Version	Date	Authors	Status	Comment
1.0	April 2012	Jane Connor, Petra Nittel, Paul Gocke, Mark Anderson (BLT)	Final	To replace winter surge plan and to centralise information in service specific documents
1.1	June 2012	Gail Sad	Final	Amendment to describe Virtual Ward escalation and admission procedures during a surge both in acute and primary care organisations.

2.0	January 2014	Christine Callender for EPCT Maggie Parks for EHCC Katie Render for CNNT	Final	Amendment to clarify that agreement that patient is suitable for discharge by Community Matron before discharge planning commences. Community Matron on-call will co-ordinate referrals instead of Matron for Inreach. Amendment to clarify admission criteria to East Ham Care Centre. Update of CNNT section

Contents

1. Overview

Newham residents are able to access a variety of hospitals within London for secondary healthcare and outpatient appointments. In the event of a major incident or surge in admissions Acute Hospitals may increase the level of discharges into home and community settings to increase the bed availability for urgent admissions. East London NHS Foundation Trust (ELFT) is responsible for the provision of community healthcare services to Newham residents through Community Health Newham (CHN) and is therefore responsible for assisting Acute Trusts to discharge individuals to homes and facilities within Newham during a major incident. Barts Health NHS Trust are responsible for services provided at Newham University Hospital (NUH), Mile End Hospital, Whipps Cross Hospital, The Royal London, The London Chest Hospital and St Bartholomews Hospital as well as community healthcare services within Tower Hamlets.

This document should be read in conjunction with any Winter Pressures / Surge arrangements and reporting requirements. It is intended to outline accelerated discharges during a major incident or unexpected surge in admissions rather than a planned increase due to seasonal pressures or planned closures.

There is a possibility that CHN services may be affected by the same circumstances that prompt the accelerated discharge request by an Acute Trust. In that case business continuity plans will be activated and the extent of the capacity of CHN services communicated once a request for accelerated discharge has been received.

2. Newham Discharge Process

ELFT's Community Health Newham Directorate work with Newham General Hospital and the London Borough of Newham's Adult and Children's Services to ensure individuals are able to return to their home or an alternative community facility when leaving hospital. This may include a package of care or provision of equipment, social support and community nursing amongst others. In the event of a surge in demand within an acute setting, individuals will still need to be assessed and support put in place before being discharged. Provision of medication from the hospital pharmacy to individuals being discharged will also need to be expedited. Incidents causing widespread disruption to local roads may delay the discharge of individuals and prioritisation of patient transport may be needed.

In the event of a major incident being declared by the Hospital (or Acute Trust as a whole) will assess individuals within the hospital with a view to identifying potential discharges. In any incident, it is difficult to assess the number of casualties who may require treatment and admission by individual hospitals and therefore the number of individuals assessed for potential discharge is often high.

3. ELFT (Community Health Newham) Roles and Responsibilities

During a period of surge ELFT will provide:

- Business continuity of critical and essential physical primary community healthcare services within the London Borough of Newham
- Urgent Care services located at Newham University Hospital
- A single point of contact for the organisation Out of Hours through on-call rotas
- Co-ordinate and disseminate communication materials to staff, service users and the general public in relation to the health risks, additional or alternative services and business continuity measures following an incident

During a major incident (as declared by the Acute Hospital or Hospital Trust) ELFT will:

- Co-ordinate the provision of primary community healthcare services within the London Borough of Newham
- Treat minor injuries in line with the current services provided at the Urgent Care Centre, or other Urgent Care facilities where necessary
- Co-ordinate the acceleration of discharges to community facilities or individuals homes to maximise acute bed availability
- Maximise capacity within community in-patient facilities (e.g. East Ham Care Centre) to reduce the demand for secondary care where possible
- Prioritise services within the Virtual Ward / Extended Primary Care Team to increase the number of individuals being discharged who can be cared for in their own homes or community / residential facilities
- Assist with the provision of prescription medication to discharged individuals to escalate discharge times during disruption to normal hospital pharmacy arrangements

During a major incident involving risks to public health ELFT will:

- Assess the potential health risks to vulnerable groups including business continuity measures for at risk individuals (e.g. medically dependent individuals, children with complex needs)
- Assist the Cluster and Health Protection Agency with the distribution of mass countermeasures including provision of vaccines under PGD arrangements
- Assist the Cluster and Health Protection Agency to disseminate public health advice to staff, service users, at risk individuals and the general public

4. Responding to a Request for Accelerated Discharge

In the event of a request by an Acute Hospital (e.g. Newham University Hospital (NUH)) to accelerate the discharge of individuals, the Acute Hospital's Incident Director of Director on-call should notify ELFT's on-call Director. Any incident resulting in a large number of discharges may have a wider impact on the local healthcare economy and also may affect the provision of services or access to the Newham Centre for Mental Health located on the Newham University Hospital site. The ELFT Director on Call is responsible for notifying the

appropriate CHN personnel and escalating issues to CHN's Silver Incident Team (or appropriate Managers / Service Leads if an incident team has not been established).

Once the number and type of discharges have been identified by the Acute Hospital the ELFT CHN discharge function will liaise with the NUH Discharge Team the relevant Social Services functions to ensure that a package of care is in place in order to discharge the patient. Built into this process is the agreement by Community Health Newham Services that patients' needs can be supported.

In the event of a major incident cancellation or stand-down for NUH andELFT, CHN will liaise with the hospital's incident team regarding the re-admission of patients who have been moved into ELFT in-patient settings on a temporary basis. If the incident has caused a surge in demand for community healthcare services, business continuity measures may be required including re-admitting individuals whilst medium and long term solutions for discharge are assessed
Moving patients back to acute care provision will be dependent on the bed availability at NUH. Potentially poor outcomes associated with repeatedly moving frail and elderly patients need to be considered, including requirements of the Dementia Strategy.

5. Virtual Wards and the Extended Primary Care Teams Process for Accelerated Discharge from Newham University Hospital (NUH) and Admissions from Social Care and GPs

Existing Virtual Ward (VW) patients will be reviewed with a view to discharge to Extended Primary Care Team (EPCT) services under the supervision of the VW Community Matron. This will allow additional capacity to accommodate discharges from NUH.

Once NUH's acute incident director/on call director has informed ELFT's on call director of the need for Accelerate Discharge the In Reach Community Matron will take responsibility for review and suitability for discharge in partnership with NUH staff, this will reflect the VW and EPCT criteria (App A).

Across Newham there is access to 60 VW beds and all referrals are triaged within the urgent (4 hours) and non- urgent (24 hours) framework.

Referrals will then be co-ordinated by the On-Call Matron. Decisions will be made about the suitability of Tele Health, Virtual Ward, East Ham Care Centre or Extended Primary Care Team referrals.

GP and social care admissions can be referred to EPCTs, including the VW service, via the usual referral route and care packages can then be negotiated between NUH and the VW social care co-ordinators as needed.

Therapy referrals for Physiotherapy and Occupational Therapy will follow the established referral routes via fax to specific localities.

6. Patient Transport

In the event of a major incident causing disruption to the local transport infrastructure, the Acute Hospital incident team and ELFT's on-call Director / Incident Team should liaise regarding the prioritisation of patient transport. ELFT has contracts with M&L to provide patient transport and also an internal delivery service and Taxi Hire contract which may be used to expedite patient transport. ELFT staff are not insured for the transport of patients. The Acute Hospital will be responsible for liaising with the London Ambulance Service regarding transport of discharged patients unless otherwise agreed with ELFT as patients may also be transferred to other Acute facilities or Boroughs as well as Newham.

7. East Ham Care Centre – Intermediate Care - Cazaubon Unit

The East Ham Centre (EHCC) is a LIFT initiative in a modern purpose built facility providing comprehensive community health care services to Newham Residents over the age of 60 years including services for in-patients for NHS Continuing Care; Intermediate and respite care; an Activities Centre; a Day Hospital and Falls Prevention Service for Older People.

The Cazaubon Unit currently has provision for 16 Newham Consultant Led Intermediate Care beds; up to 5 beds for short stay respite care lasting up to 4 weeks; and 2 Community Led beds. The latter are clinically managed by Primary Care (GPs) and other community based health professionals such as Community Matrons and Specialist Nurses. All referral forms and full procedures are set out in the ELFT Cazaubon Unit Operational Policy. The services are for Newham residents who need rehabilitation /intermediate care for up to 6 weeks within the following categories:

- **Rehabilitation/early discharge** - Those who have been discharged from a stay in hospital but require some additional rehabilitation due to their medical condition to regain confidence and skills to enable them to manage at home again, as independently as possible. This also supports timely discharge from an acute hospital bed therefore reducing delayed discharges.

- **Crisis intervention due to a long term condition** - Those who are experiencing a crisis or deterioration in their health due to either a long term condition or an acute illness, which is temporarily disabling them to manage independently at home, but does not require the supporting technology of an acute hospital admission.

- **Admission avoidance** - Those for whom admission to the acute hospital is unnecessary; or admission to residential or nursing home has been or is being considered and the patient would prefer or has the potential to return home with

community support can prevent **premature admission** into long term residential care.

Patients referred for intermediate care admission to the Unit need to be medically stable and not in an acute stage of illness. Referrals are accepted from health or social care professionals in the community, hospital and primary care services.

Normal Intermediate Care referrals criteria:

- Eligible patients will be adults over the age of 60 years, who have recovered from the acute medical stage of illness and meet the following criteria (eligibility checklist):
  - medically stable for at least 48 hours
  - patient able to participate in rehabilitation on admission
  - no significant changes in medical management anticipated
  - patient could potentially benefit from active nursing/ rehabilitation intervention in one or more of the following –education/psychological care/mobilisation/symptom control/nutrition/feeding/wound care/ nurturing
  - routine investigations results (bloods and ECG) are available and, where any abnormalities are present, a clinical course of action has been agreed and documented
  - discharge destination has been identified
  - a maximum stay of 6 weeks is envisaged
  - patient understands and consents to rehabilitation in the Unit
- Resident in Newham and registered with a Newham GP.
- The Hospital Consultant and the MDT have assessed the patient and agreed they have completed the acute episode of their care/ do not require acute hospitalisation, is appropriate to be managed in the Cazaubon and be under the care of the MDT in the Unit.
- Patients demonstrate an understanding of the contribution they will need to make towards their rehabilitation, they consent and are willing and able to participate in the rehabilitation, activity or enabling processes eg. have some standing balance, cognitive ability to follow instructions, etc.
- A rehabilitation programme for a week to six weeks will improve their independence and to which their family and/or carers agree to.
- Are assessed as able to benefit from rehabilitation in a ward setting and not primarily waiting to go to a residential / nursing home, unless a transitional admission is proposed, i.e. prevention of premature admission to long term care by reinforcing a rehabilitative programme in a step down facility instead of an acute hospital setting.
- Patients with infectious diarrhoea or vomiting or diarrhoea and vomiting of unknown aetiology will not be accepted/admitted to EHCC

Emergency Placements to Cazaubon Unit from the Community

- Emergency / short notice placements can be considered providing that the Cazaubon Nurse- in-charge is satisfied that the criteria for admission to the Unit is met i.e. client does not require an acute hospital admission and there is a bed available.

- The client has agreed to the admission to the Cazaubon Unit and is aware of reason for admission (medical summary including test results if any, reasons for referral, medications, GP agrees to provide clinical cover while client is in the Cazaubon).

- The Social Worker and clinician in charge (GP/ Community Specialist/ Community Matron) agrees to carry out a review within 72 hours of placement. S/he will liaise accordingly with the Cazaubon Unit staff, and jointly make a decision as to appropriateness of continuing the placement or referring to the Care of the Elderly team or an alternative placement.

Escalation Procedures for Admission to EHCC from Hospital in the event of Surge / Beds Crisis:

- EHCC Senior Manager (SM) must be notified of a Beds Crisis alert in the Hospital (e.g. Newham General). The Senior Manager will liaise with Matron and Cazaubon Nurse in Charge to confirm beds availability/ status. Patient safety must remain paramount during the escalation and transfer process.

Hospital must send referral by fax marked
URGENT FAO: Matron EHCC
Fax No: 0208 475 2122

- Matron will liaise with the CHN Discharge Team / Hospital Discharge Co-ordinator and confirm outcome, including agreed patients to transfer, based on:

    - Patient and family have agreed to the transfer to the Cazaubon Unit.

    - Documented evidence shows patient is known to and assessed as medically stable by Care of the Elderly Team and recommended fit for transfer.

- Cazaubon Nurse in Charge to ensure Admission procedure adhered to according to Key Operations of Service S.5.

8. CHN Children's Nursing Teams

The Community Children's Nursing Team (CCNT), Continuing Care Nurse Specialist, Epilepsy nurse Specialist and the Diana Children's Community Team are components of the Services for Children and Young People within the Community Health Newham Directorate. It provides a range of services to support children who reside within the London Borough of Newham, requiring skilled nursing care, palliative care or skilled technical support nursing within their home or other community setting. The Diana Team also leads on bereavement support.

In the event of a major incident, the Nursing Team would review capacity and seek to admit children under the following standard admission criteria:

A child/young person aged 0 – up to 16th birthday (Children 16 and over must be referred to the District Nursing Service through their GP)

A child/young person who is resident within the London borough of Newham

A child/young person who has a requirement for Technical/Skilled Nursing Care, Symptom Control management or where teaching the clinical care of a complex health need is required to allow a child to remain at home or attend school/nursery/respite setting.

(The following criteria may help in identifying whether the child is a suitable candidate for service and to triage to appropriate team). Does the child/young person require:

Technical Skilled Nursing Care – Child/ Young person requires a specific identified technical nursing procedure (eg: intravenous medication, subcutaneous medications, blood taking, wound care) - CCNT

Symptom Control/Management – The child requires a period of regular assessment and monitoring of symptoms which requires skilled nursing supervision or management, (eg: pain control in children requiring palliative care, exacerbation of chronic conditions – eczema/Asthma, monitoring for children undergoing treatment for ALL/ babies on oxygen therapy) – CCNT / DIANA

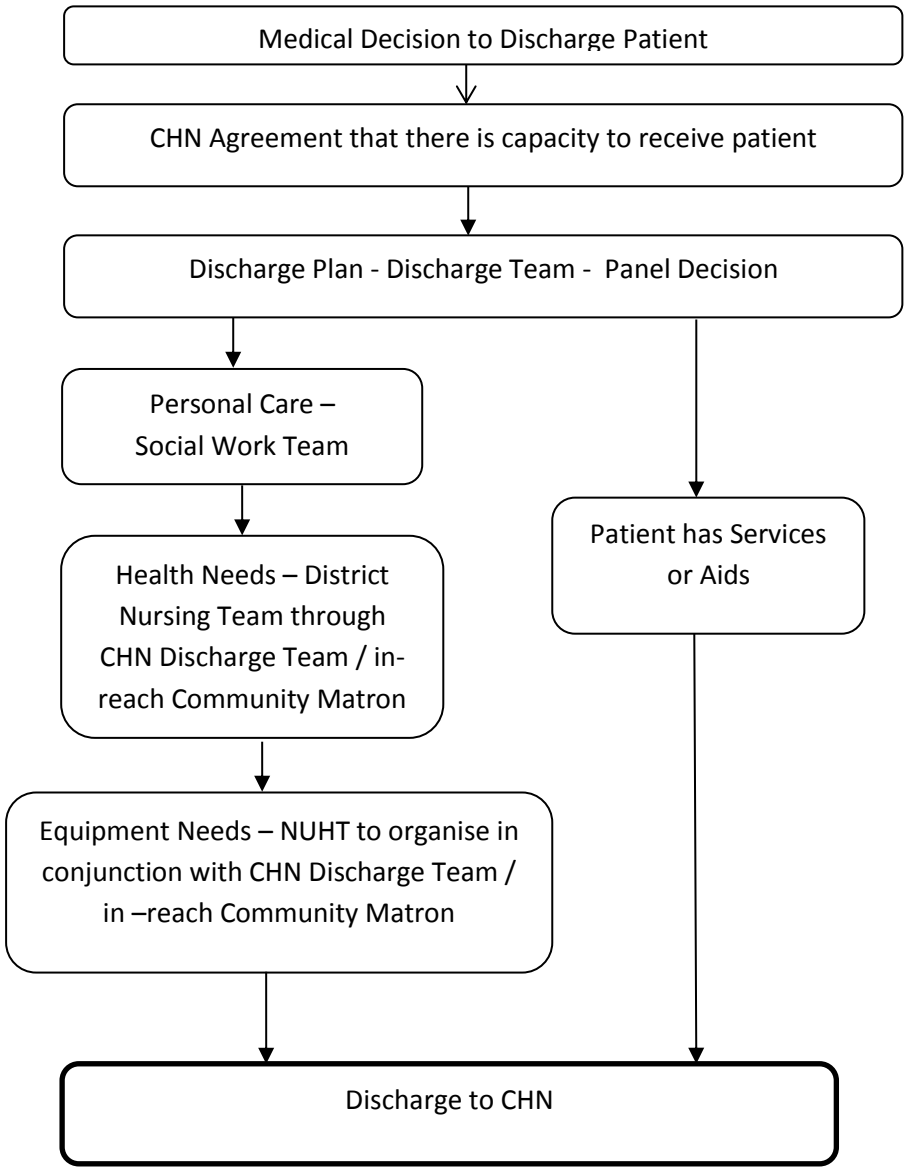
Education – The child/young person or parent/carer requires education to enable them to continue providing support for ongoing treatment, care needs or therapies relating to the child/young persons condition (eg: administration of medications, artificial feeding routes and care of same, suctioning, oxygen therapy, tracheostomy management)- DIANA and CCNT

Technical Care Support Package – Child /young person requires long term assisted ventilation support / increased clinical technical input that family are unable to provide on 24 hour basis without support to maintain child/young person at home or other community setting.(co-ordination of package of care required) – Continuing Care Nurse Specialist

Palliative / terminal care – Child/young person has life limiting illness. This is delivered by the DIANA team in partnership with the team around the child. The team will support families in choosing how and where end of life care if delivered.

Referrals will be handled by the designated triage nurse daily between the hours of 09.00-16.00. CCNS require 48 hours notice of any admission to their care and will make first contact with families within 48 hours of receiving referral. In event of a major incident, Newham General's incident team should contact Community Health Newham regarding any emergency admissions to the service.

9. Accelerated Discharge Flowchart



Appendix A

Tel: 0844 409 9345
Fax Numbers: Central- 0208 475 2146, North East- 0208 553 7420,

North West- 0208 536 2158, South- 0207 445 1193

Out of hours contact: 0207 403 7771

Email: virtualwardhub@nhs.net

REFERRAL to the Newham Extended Primary Care Service

including the VIRTUAL WARD

DATE OF REFERRAL……..

PATIENT NAME…….GENDER……..

PATIENT ADDRESS……

POSTCODE……..

PATIENT CONTACT TELEPHONE NUMBER……

PATIENT ETHNICITY……

IS THE PATIENT ABLE TO SPEAK AND UNDERSTAND ENGLISH? YES / NO

PATIENT NHS NUMBER……PATIENT DOB……..……..

GP DETAILS……

NEXT OF KIN/EMERGENCY CONTACT DETAILS:

……
……

What is the patient's presenting problem / diagnosis
……
……
……

Is this an acute or chronic episode? CHRONIC / ACUTE

Has the patient had a recent exacerbation of their chronic disease? YES / NO

Is the patient at risk of rapid medical decline and / or medically unstable and at risk of hospital admission?

YES / NO

If YES please state why…….....
……
……..

Allergies? YES / NO please specify…….

Is the patient currently in receipt of a social care package? YES / NO If yes please give details……

Would the patient benefit from case management? YES / NO

This referral is for the Community Health Newham EPCS/Virtual Ward

RELEVANT Past Medical History
……
……..

CURRENT MEDICATIONS (PO, GSL, POM)
……
……
……

……

Reason for referral:

……
……
……
……

OTHER SERVICES INVOLVED WITH THE PATIENT:

1) .
2) .
3) .
4) .
5) .

NAME & DESIGNATION OF REFERRER

…….

CONTACT DETAILS OF REFERRER……..

For office use only;

Date/time	
Triage Score	

Rationale	

Outcome	
Clinician	

Where possible please send EMIS summary with referral