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| For further information about the service or to provide feedback  contact Fiona Davies, Clinical Lead on phone: 020 7771 5753  or e-mail: fiona.davies3@nhs.net  To contact the team or rearrange your appointment, call  **020 7771 5750**  **OR after 5pm and at weekends**  **Call via the Single Point of Access: 0300 033 5000**  If you wish to make a complaint contact:  **FREEPHONE**  **0800 085 8354 or by email**  **palsandcomplaints@elft.nhs.uk**  **East London NHS Foundation Trust**  : [www.elft.nhs.uk](http://www.elft.nhs.uk/)  <https://www.elft.nhs.uk/> | | cid:image003.png@01D2E9E8.9A417030 | |
| You are receiving visits from the:  Admission Avoidance & Discharge Service (AADS)  ***Helping you identify your community support requirements at home following hospital admission or A & E attendance***  **Contact our team: (9am – 5pm) on 020 7771 5750 or -**  Contact your key worker  Name:  Number: | |
| cid:image003.png@01D2E9E8.9A417030  cid:image004.png@01D2E9E8.9A417030 | |
| **Discharge to Assess - What you can expect from the service**  The Admission Avoidance & Discharge Service (AADS) is one of the community services run by East London NHS Foundation Trust.  The AADS pathway uses a model called “Home First” or “discharge to assess”; based on the principle that most peoples’ on-going health and care needs are best assessed at home. Once you no longer need to be in an acute hospital environment, we will meet you on the ward to facilitate your discharge home and help you recover safely.   * We will assess your immediate needs on the ward or in A&E   and if you need carer support, this will be arranged before you  are discharged from hospital, then reviewed by a social worker once you are at home as it is likely to change.   * This support will often be via the Reablement service. * We will visit you at home to assess your needs within 24 hours of your discharge from hospital. * You will be given the name of your key worker and be   provided with a number to call them if you have any questions  about the pathway or need to rearrange a visit.   * The maximum period the service will be provided is 6 weeks.   During this time we want to help you become as independent  as possible.   * If you need further assessment from the community health team or social services, this can be arranged for you. * A financial assessment will be required if you require on-going social care. | **Who works in the community Admission Avoidance & Discharge Service?**  Our team includes:   * Nurses * Physiotherapists * Occupational Therapists * Social Workers * Rehabilitation support staff * Reablement Officers   The team members work closely with the Reablement Service, your GP, the Extended Primary Care Teams and other support services in our community.  **What we expect from you and those important to you**  We expect you or someone important to you to take an active part in your assessment and in identifying what you need to return to independence or to plan your future care.  We also need you to participate in your agreed rehabilitation programme and to be welcoming and respectful to our staff.  You may be contacted to share your views on the service. Close friends and family who have been involved would also be welcome to share their views. This will help us to understand what we are doing well and to make improvements to our service. |