Integrated Community Service: Admission Avoidance Launch

A new Community Admission Avoidance service will be launched on the 5th October across Shropshire. The service will provide rapid assessment and interventions for people over 18 years of age.

Patients accepted by the Integrated Community Service will be experiencing an acute deterioration in their health or well-being which, without the input of this service, would result in acute hospital admission.

The team includes Nurses, Physiotherapists, Occupational Therapists, Social Workers, Assistant Practitioners and Support workers and has access to a range of domiciliary and bed based care.

Coverage

Our service is for people aged eighteen and over who are registered with a GP practice or who are resident in Shropshire. The service does not accept:

- People who require end of life care (where death is imminent in days/weeks)
- Where the individuals primary need is relating to:
  - Mental Health
  - Substance Misuse
  - Learning Disability

How to Access

Any health and/or social care professional can refer in to the service.

Contact SCHT Single Point of Referral on - 01952 580338

ICS has a dedicated telephone line for Admission Avoidance covering the whole of the County. This is not a referral line but health and/or social care practitioners can talk to an ICS practitioner about potential referrals or to update the service in relation to referrals made. The telephone number is - 01743 277701

ICS Provide:

- The service is being introduced through a phased approach and so from the 5th October 2015 it will operate 8am-6pm, 365 days a year accepting the last referral at 5pm.
- Once the referral has been accepted, patients will be visited within 1-4 hours depending on their clinical need.
- An initial assessment of health and social care needs will be undertaken and a plan of care is agreed with the patient and their carers where appropriate to enable the patient to remain at home.
- Based on the needs of the patient, the team will visit to implement the care plans and facilitate patient safety, sometimes in collaboration with specialist services where required.
- Where appropriate, the service will coordinate a short-term care alternative to acute hospital admission possibly onto a nursing or residential home.
- Once the patient is stabilised, a comprehensive holistic assessment will be undertaken. If the patient has rehabilitation and/or reablement potential, the team will continue to work with them up to a maximum of 6 weeks.
- On discharge from the service the service will ensure a safe handover to appropriate services and liaise with the patients GP.
ICS Admission Avoidance – High Level Pathway

The service will provide rapid assessment and interventions for people over 18 years of age who have an unpredicted acute exacerbation of a long term condition and/or a rapid deterioration in health or wellbeing.

Exclusions to the service
- End of Life care (where death is imminent in days/weeks)
- Where the individuals primary need is relating to:
  - Mental Health
  - Substance Misuse
  - Learning Disability
- Referral to SCHT Single Point of Referral (SPR) – 01952 580338
- SPR telephone ICS Admission Avoidance hotline & follow up with email referral document.

The service operates in phase 1 from 8am – 6pm (last referral 5pm)
Response within 1hr for ‘urgent’ and within the same day for ‘semi-urgent’ referrals, the ICS Worker:
- Collates information
- Deploys duty worker
- Informs GP & referrer of plan

- All ICS patients will be allocated to a key worker once accepted onto the caseload.
- The key-worker will accept clinical accountability for the individual and will arrange interventions to meet individual health and/or social care needs.
- The key worker will request medical input from the patients GP, DAART, Mental Health, Community Pharmacists and/or other specialist services should this be required.

Patients will be discharged from the service:
- If the assessment at home identifies they have long term needs which could be better met by another external service
- As soon as they have achieved their identified goals.
- Patients will remain with the service for a maximum of 6 weeks, although the average duration will be 24 days.