Health & Adult Care Scrutiny Panel

Patient Pathway: Discharges from Hospital including Adult Safeguarding, Social Care and Accommodation
Report Authors

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The re-design and development of the Extended Hospital Social Work Service (EHSWS) was part of the Council’s modernisation towards improving outcomes for frail and vulnerable people. The EHSWS has high level synergy with the development of a model of community, locality social work delivery, which is now in place.

The remodelled EHSWS which came into affect on 1\textsuperscript{st} November 2014, provides a faster streamlined response to ensure timely transfers of care from wards and preventing unnecessary admissions to hospital, through the proactive presence of members of the hospital social work team at the ‘West Middlesex University Hospital-WMUH emergency front door’ - Emergency Department (ED) 7 days per week. In essence the service will work avoiding unnecessary admissions and work to ensure that people who require ASC input leave hospital in a resident centered, safe and timely way.

The EHSWS was funded from 1\textsuperscript{st} November until 31\textsuperscript{st} March 2015 by winter resilience money and then for 2015/16 by an allocation of money from the Better Care Fund (BCF).
The additional funding has enabled the development of the hospital social work service to provide sufficient capacity to enable a service available during:

- weekdays from 8am to 8pm

- At weekends and public holidays from 9am to 4pm, enabling people to be deflected from ED and safely discharged from hospital wards 7 days per week.

- From April 2015 staffing complement is as follows:

<table>
<thead>
<tr>
<th>Location of Service</th>
<th>West Middlesex University Hospital/ Ashford &amp; St Peter’s Hospital</th>
<th>Charing Cross (covers Hammersmith and St Mary’s Hospital)</th>
<th>ICRT</th>
<th>Palliative Meadow House</th>
<th>CRS</th>
</tr>
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<tbody>
<tr>
<td>No. of Social Workers</td>
<td>8</td>
<td>1</td>
<td>1</td>
<td>1 SSW</td>
<td>1.5</td>
</tr>
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- There is 1 TM and 1 deputy TM and from June 2015-April 2016 an extra deputy funded from system resilience funding
The EHSWS is currently working with WMUH to safeguard and ensure safe discharge:

- Seven day a week adult safeguarding investigations undertaking to effectively safeguard vulnerable adults with joint working to identify and address safeguarding concerns
- Intervene where there is a situation when a person comes to A&E for social care reasons e.g. family/carers arrangements have broken down/housing issues etc and provide support and direct intervention to resolve safeguarding concerns.
- Social work presence in ED, AAU, AMU1 and AMU2 x 7 days per week to facilitate alternatives to hospital admission when this is not necessary and provide advice and joint working with hospital staff.
- Divert people away from ED when they do not require inpatient care and facilitate safe and speedy discharges from wards.
- Set up urgent care packages outside of the usual office hours to enable someone to return home safely from a ward or prevent a hospital admission.
- Provision of advice, assistance and signposting to obtain community resources as required to prevent future need.
- Restart of packages of care to facilitate discharge and reduce the number of delayed transfers of care (DTOC).
Discharge destinations

• To resident’s own home or family home (with the support of the Red Cross to settle into the property if no family or support at home - to ensure food/heating/all is ok etc)
• Liaise with Housing to resolve housing issues
• Sheltered housing
• Extra Sheltered Care (Greenrod and Park Lodge- new 36 bed unit which opened in July 2015)
• Interim 24 hr care arrangements if cannot return home
• Residential care
• Nursing Care
The EHSWS is working closely and has interdependencies with:

- Joined up/partnership working between EHSWS and WMUH Discharge planning team who now sit and work together at Percy House based at the West Middlesex Hospital to ensure safe and appropriate discharge.
- Prevention of hospital admission and discharge of complex cases through multi-disciplinary referrals to the Integrated Community Response Service (ICRS) and Community Recovery Service (CRS) for prevention of need and recovery/rehabilitation.
- Monthly meeting between health and adult social care re frequent attendees.
- Monthly meeting with CID (Cognitive/Dementia Team) to discuss complex patients on ward and in community
- On-site Red Cross in facilitating transport/assistance that may be required for patients returning home from WMUH.
- Ongoing teaching program for ED staff in developing the EHSWS working.
- Joint work on Safeguarding of vulnerable adults
How West Middlesex University Hospital is improving joint working

• Discharge Governance meeting
  – 6-weekly meeting to review learning from discharge concerns

• Hounslow Complex Patient Review
  – Monthly multi-disciplinary team review of complex patients with frequent attendances to ED

• Weekly length of stay meeting:
  – Review of all patients who remain in hospital over 20 days
Case Example

- Mr X admitted to WMUH following several strokes caused by a genetic condition. He was in his 50s.
- Mr X was left with severe cognitive impairment and unable to return home due to his high risk of leaving the house and very limited safety awareness.
- Family were very concerned about placing the gentleman into a nursing home given his young age.
- The family were also dealing with their own emotions and being tested for this genetic disorder.
- Joint working between Hounslow Social Services and WMUH allowed this gentleman to be placed successfully in Park Lodge with the support of the family and a personalised package of care to meet his needs. This included a discharge home visit from the WMUH OT and also follow-up with ICRS.