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Pathway for Oxleas Service Users admitted to the PRUH

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BACKGROUND

- MH service users admitted to PRUH; physical health
- Acknowledgement of poor service user/carer experience historically
- Acknowledgment of specialist skills and competencies
- Mental Health practitioners assessing needs and care packages to support post discharge physical health needs
- Skill set of Transfer of Care Bureau (ToCB) staff- reablement; packages of care

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CONTEXT and NATIONAL DRIVERS

- Recognise the need to provide efficient and effective care as part of treatment pathway
- People living longer
- Co-morbid, complexity of needs
- Need for joint working across services
- Avoid DToC

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CONTEXT and NATIONAL DRIVERS

- Parity of Esteem- addressing the physical illnesses of people with severe mental health problems
- Statutory Framework:
  - MHA- Section 117
  - MCA
  - Care Act 2014

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HISTORICAL CASE STUDY

- Service user- heart failure and CKD stage 4 (8 admissions in 12 months)
- Diagnosis of Schizophrenia
- No assessment or interventions offered as known to Oxleas
- Not offered reablement
- Limited communication between PRUH and CCO re discharge plans
- No co-ordinated discharge; no follow up of physical health needs
- Dom Care stopped with limited notice
- POC via MH PRG (caused delay); no access to POC via ToCB
- Professionals Meeting- OT assessment; joint working; equipment; joint discharge planning
- Only one further PRUH admission since; due for discharge from Oxleas

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AGREED PATHWAY FOR SERVICE USERS

- Draft Pathway
- ToCB will notify Care Co-ordinators (CCO) of admission
- Complex Health and Social Care Needs- agreed joint assessment to support discharge planning
- Support with service request for Dom Care from ToCB
- Reablement (6 weeks) now accessible to Oxleas' users
- ToCB resources available for Oxleas' service users, to support discharge
- Complex Care support, for ongoing physical health conditions

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CASE STUDY

- Mr G - decline in diabetes; non compliance with medication; fall
- Living at home; CCO due to personality disorder, depression and anxiety.
- Mr G fit for discharge - notification of assessment (NOA) to CCO
- Joint assessment with the hospital Social worker and ward team
- Agreed discharge plan: Access to domiciliary care on discharge to support reduced mobility, compliance with medication; self-care
- Ongoing review by CCO and reablement access identified
- Timely discharge; effective utilisation of resources across system

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FURTHER DEVELOPMENTS/NEXT STEPS

- Extra Care Housing (ECH)Access Review
- Reablement- Briefing sessions for Oxleas staff
- Domiciliary Care- mental health awareness training
- Joint Transfer of Care Bureau (ToCB) and Oxleas briefings to promote joint working and improve access to care
- Monitoring progress