TRANSFER OF CARE WARD

Background

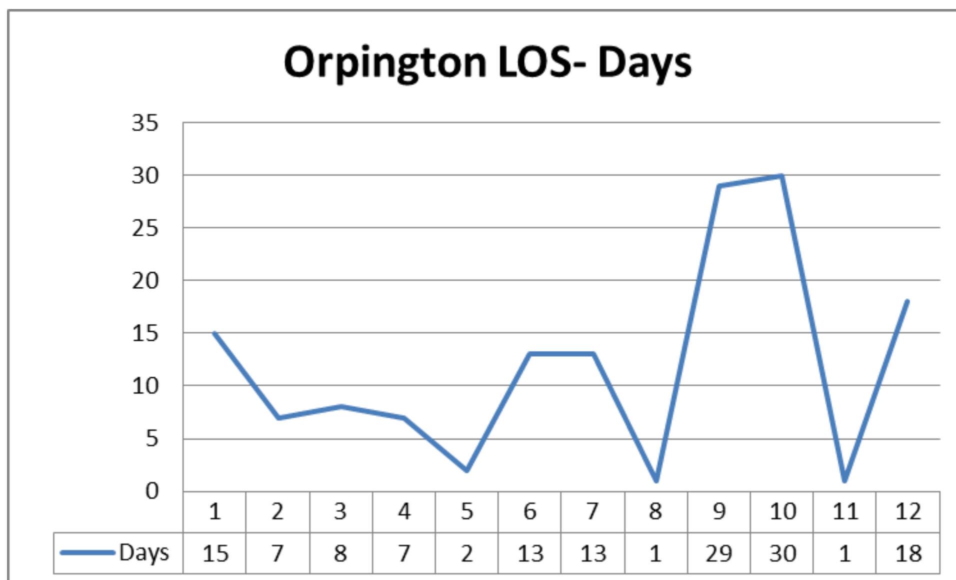
It was recognised that the service being delivered by the Medical Response Team (MRT) was delivering the stated aims for the patients who were able to return to their own home. This was being scoped by the in-reach model at the PRUH and will be evaluated to include key staff from both community and social service backgrounds

This pathway needs to ensure that whilst in-reach supports the largest number of patients (approx 25-35 per week) there was no service in place to offer early discharge to patients who were not able to return home.

In order to achieve the aims for patients who could not return home new pathways and ways of working between health and social care needed to be developed. In November we secured 8-10 beds in Orpington this was a partnership between NHS BCCG, LBB with the aim to achieve discharge to assess for patients who could not return home straight away.

Average LOS was 12 days - however 2 patients remained in the unit for up to 20+ days. This was due to family related issues/ Nursing Home availability and poor funding arrangements identified by the team.

16 patients used the service, 3 patients became medically unwell 1-2 days after admission and were sent back to the PRUH



	1	2	3	4	5	6	7	8	9	10	11	12
Days	15	7	8	7	2	13	13	1	29	30	1	18

The Proposed Pathways to Achieve the Future State

Transfer of Care Beds – 'Discharge to assess' where home is not an option at the point of discharge, but permanent residential care is not inevitable

This pathway should be used for individuals who cannot return home, even with availability of any of the services available From BHC. These patient situations can be considered as medium to high complexity (or, in social care terms, 'critical' levels of need/risk). Patients will be discharged to a bed-based facility able to provide intermediate type care for a period of 2 - 6 weeks. The anticipated exit route from the pathway is either back home (with support if needed), or to Extra Care Housing or residential care. The patient will have given consent to care and support provided, along the journey. Currently we have a number of extra care housing beds- the oversight and management of this should rest with the Transfer of care bureau

People moving through this pathway will be considered for appropriate transfer to In-reach/MRT (or rebranded to be known as TOC @Home) at the earliest safe opportunity to do so. This pathway will provide the maximum benefits for this cohort and reduces the risks of ongoing residential/nursing care settings being required to meet their residual needs.

Transfer of Care Beds – 'Discharge to assess' to nursing home, where patient needs are very complex and where Continuing Health Care (CHC) eligibility is a possibility destination unknown.

This is a new pathway for Bromley. Patients will be discharged to M4 Transfer of Care Ward for a period of 4 – 6 weeks. During this time, patients will be offered an environment in which to recuperate / rehabilitate as far as possible, and will be assessed for CHC eligibility.

Transfer of care will provide case management and rehabilitation / reablement planning and support to the patient in conjunction with the care home provider. The multi-disciplinary team will incorporate a GP. Patients assessed as eligible for CHC funding will have their long term care arrangements organised by the Transfer of Care Bureau (BCCG Continuing Care) and funded nursing care team. Individuals assessed as eligible for LBB social care and support (nursing or otherwise) will have their long term care arrangements organised by an allocated Social Worker. Self-funders will be appropriately supported to identify their long term care arrangements. The patient will have given consent to care and support provided, along the journey.

Some TOC@Home patients that are on the Home pathway might not be safe to remain at home following assessment- some beds here will be ring fenced so that patients can return safely whilst waiting for their placement