London Borough of Bromley

PART 1 - PUBLIC

Briefing for Care Services
Policy Development and Scrutiny Committee
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Occupational Therapy Services in LBB

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1. Summary

1.1 This report is to advise of the current situation with Occupational Therapy Services in Bromley

2. THE BRIEFING

2.1 Establishment:

2.1.1 There are currently 14.5 OT staff working in the service covering assessment for both children and adults. They are made up of 1 TL, 4 Senior OT's, 5.5 OT's and 5 Assistants (OTAs). One of the OT posts is dedicated to paediatric work.

2.1.2 The TL is dedicated to Leading on Community Equipment and Assistive Technology with an additional responsibility for providing professional supervision to the SOTs.

2.1.3 **There is also 1 SOT in the Housing Department who works on maximising adapted housing and ensuring offers of alternative housing is suitable for adaptations prior to the tenancy sign up. The post is also in place to advise on new builds to ensure they are compliant and fit for purpose. If there are any equipment needs or adaptations required the work is passed to the Initial Response or Complex Care OTs for their action.*

2.1.4 The OT's are in the Initial Response Function of the AEIS and in two Complex Care Teams. The TL for Community Equipment and Assistive Technology has no time to do more than quarterly professional supervision for the SOTs which leaves them with limited professional OT lead support.

3. Care Pathway (Customer Journey):

3.1 Of the 13.5 OT staff 4.5 work in the Initial Response Function and deal with the initial screening and assessments prioritising those at risk and ensuring equipment is ordered quickly to assist with managing any immediate risks to the individual. In high risk situations an OT assessment or intervention is carried out within 1 to 5 days. The prioritising results in some people waiting up to 12 weeks to be visited but all referrals are checked and reprioritised regularly to minimise risks.

3.2 When the individual has been seen and their initial needs addressed they are either closed to OT if no further action is required, referred on to Care Management if appropriate or to the Complex Care OTs.

3.3 There are 8 OT staff in Complex Care situated in the East and West of the borough with 3 Senior OT posts, 2 OT posts and 3 OTA posts across both teams. Individuals would usually have undergone an initial assessment prior to being referred to the complex care OTs. Their role is to complete assessments for individuals who require more complex equipment and adaptations to their environment and they also use the Medequip Contract for equipment and access funds from the Disability Facilities Grant to complete their work. Housing associations, private landlords or individuals can access this grant if the individual tenant or owners meet the criteria.

3.4 The paediatric OT post is dedicated to assessing and providing equipment to children and young people referring them to the Complex Care OTs for adaptations and applications for funds from the DFG. Children's services fund £28,000 per year towards this post.

3.5 The Care Pathway can mean that a health OT and at least two local authority OTs have been involved in their assessment so this is not the most efficient use of staff time or the most customer focussed way of working.

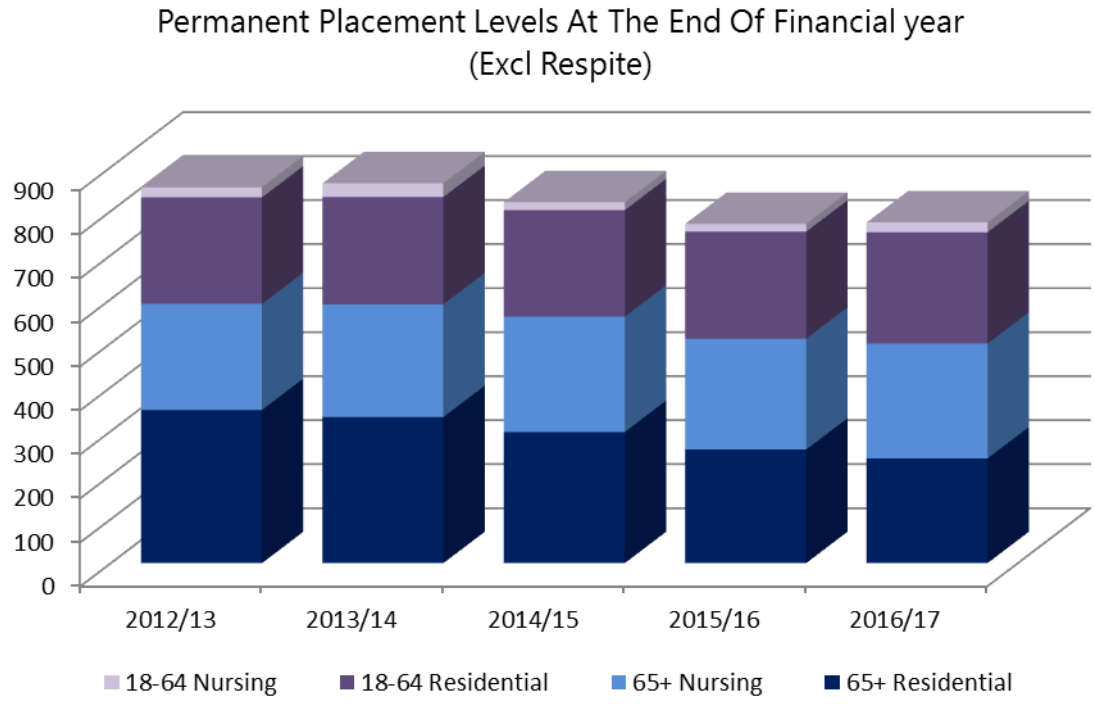
4. Demand:

4.1 The demand for OT assessments remains high and there is a current waiting list across all areas of approximately 242 individuals whom are at various stages of assessment or intervention. A significant amount of OT time is used in prioritising and managing the risks of having waiting lists and there is a clear need for the service to undergo a review.

4.2 Some of the demand is related to the higher complexity of health and social care needs because of advances in medicine. In the past people with such complex needs would not have survived or would have been managed in long stay hospitals. People are now more likely to be managed in the community resulting in a steady decline in care home placements as can be seen in the data below.

Permanent Placements As At Year End

		2012/13	2013/14	2014/15	2015/16	2016/17
18-64	Nursing	23	31	18	18	22
	Residential	242	244	242	243	253
	TTL	265	275	260	261	275
65+	Nursing	241	256	262	252	261
	Residential	348	332	298	258	238
	TTL	589	588	560	510	499



4.3 The reduction in placements is not mirrored by a reduction in people being supported by adult social care which means we are managing people with far more complex needs in the community as suggested in the March 2017 Performance Digest. The demand on OTs has grown but our staffing capacity has not and this needs to be addressed if we are to continue manage the demand required to maximise independence and therefore reduce or delay the need for care.

4.4 The recent mobile working pilot in the Initial Response function gave early indications of a 40% increase in OT assessments which I believe is a starting point for all OTs across the service.

5. Solutions/Ideas:

5.1 Immediate:

- A meeting with the OT's to discuss options which may assist in gaining additional ideas and or moving the solution ideas forward.
- Provide IT kit for mobile working and implement an 'in the field - offsite system' where the office is a drop in rather than a place to work.

5.2 Short term:

- Allow health OT's to refer directly for a DFG to remove some of the barriers and unnecessary interventions from several OT staff (make every contact count).
- Move Complex Care OT's to the Civic Site and co-locate them with Environmental Services to allow for dialogue when 'health OT referrals come in' and to be closer to the Housing SOT and the Initial Response OTs for greater efficiency and to cut down duplication.
- Obtain additional funding from children's to reflect the demand in that area of the service.
- Agreement for the paediatric OT to be integrated with the health OTs in the Phoenix Centre as previously piloted saving duplication for children and young people and efficiencies for health and social care.

5.3 Medium Term:

- Review of how the LBB and Health OT's work to reduce duplication and maximise staff time.
- Consider integration of all early intervention OTs across the health and social care economy.
- Implement and trusted assessor process where other health and social care professionals could refer direct to DFG for consideration of an adaptation in certain circumstances.
- Consider a dedicated OT Lead with some of the efficiencies achieved by all or any of the above.