London Borough of Bromley

PART 1 - PUBLIC

Briefing for Care Services
Policy Development and Scrutiny Committee
4th July 2017

Delayed Transfers of Care

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1. Summary

1.1 This report is to provide an overview of the Delayed Transfers of Care situation in the London Borough of Bromley.

2. THE BRIEFING

2.1 This report is to give an overview of the Bromley position up until February 2017. The data applies to all patients who have an acute hospital stay and for whom discharge arrangements may be complex.

2.2 The majority of complex discharges, however, apply to frail and older people, those with long term conditions and those at the end of life.

2.3 National reporting on the significant pressures during the Winter of 2014 across health and social care resulted in additional monies being allocated to LAs as Winter Pressures support so that DTOCs could be alleviated

2.4 The reporting process into government highlighted the inconsistencies across the country when applying DTOC policy guidance and in the reporting of data definitions for DTOC due to the variability in interpretation of the guidance.

2.5 What followed was shared learning as to what interventions nationally were working and which ones were having the greatest impact to improve the DTOC landscape

2.6 We now have the eight high impact changes which are recommended to improve hospital discharge, with national and local events to promote the guidance

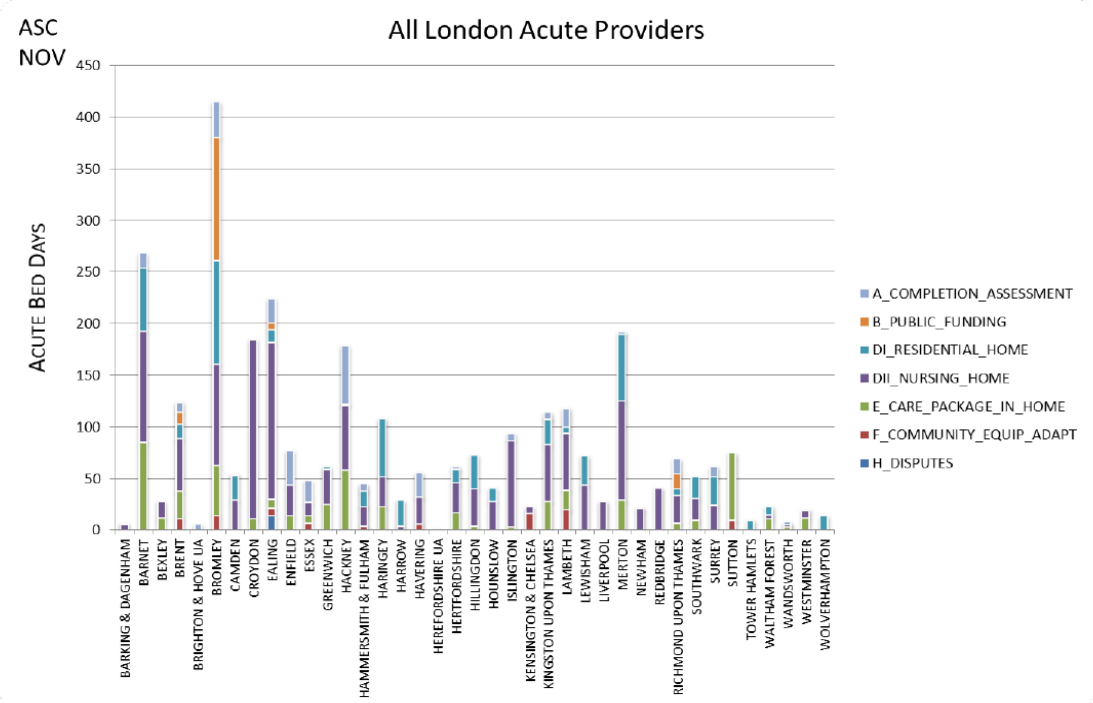
2.7 Over the past 12 months, a number of action/interventions have been implemented within and between LBB, Bromley HealthCare and the Bromley Clinical Commissioning Group to change working practices and reduce the numbers of DTOCs

2.8 The Transfer of Care Bureau (TOCB) which will be reviewed in June 2017, will also need to consider a data set and the pooling of some resources and access to support services will be needed to enable them to create packages of care for speedy discharge

2.9 We have the philosophy of home is best and should be the first consideration, with reablement as a first line of support if required. The TOCB is able to re-start care packages for residents that have had an hospital admission for less than 2 days. They also have access to the Age UK Meet and Greet Service which enables patients, without carers or family, to be transferred home safely.

2.10 Case Managers are responsible for wards and creating wrap around care packages that can be agreed within 12 hours and access to equipment and adaptations within a 24 hour period. We also offer step up and step down accommodation and are in the process of negotiating home to assess services.

2.11 During the Winter Resilience period, we have additional services to respond to the increased number of patients admitted or attending the hospital (October-March) including Rapid Response 4 hour intensive care domiciliary packages, additional support staff to prevent hospital admissions, additional social workers and nurses for community assessment and provide day and night sitting service.



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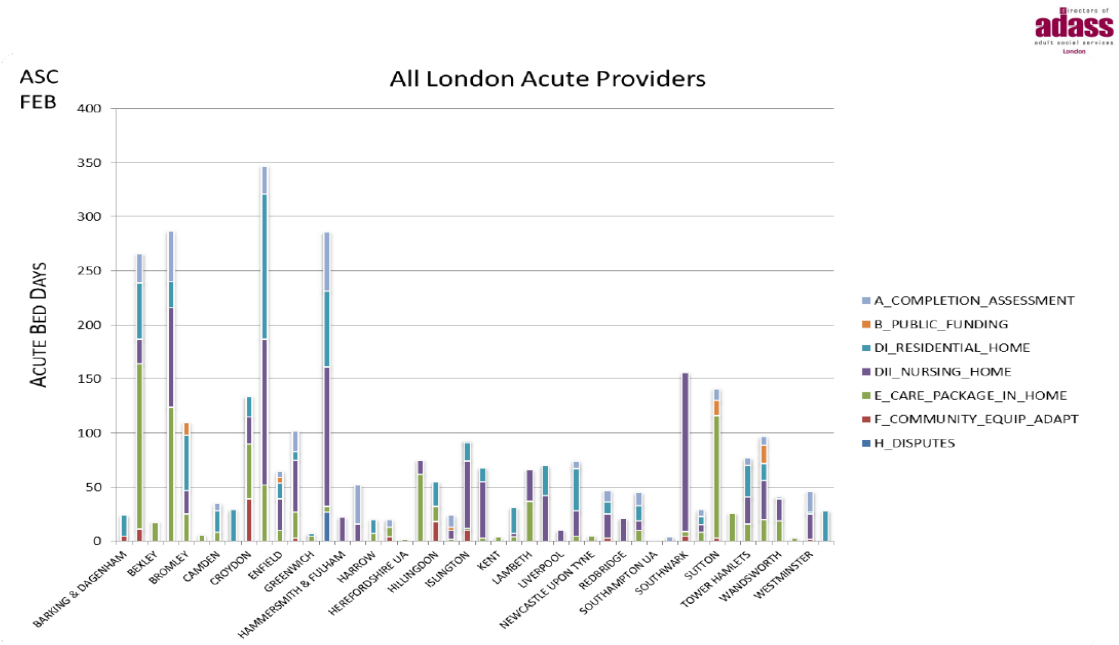
2.12 Daily teleconference and ward meetings between partners are held to keep the focus and drive on discharge and admissions

2.13 There is a non–weight bearing pathway for those patients unable to walk - but have no other needs

2.14 These actions have had significant impact on the DTOCs over the winter period.

2.15 However, Bromley remains an area where we have high numbers of DTOC compared to the National and London picture.

2.16 Overall Bromley (100+ Acute Bed Days) is showing higher DTOCs than its neighbouring boroughs e.g. Bexley (20), Greenwich (5); Bromley is, however, showing significantly less DTOCs than Southwark Sutton and Croydon.



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2.17 <u>Contributing factors for the DTOC are as follows</u>:

2.17.1 Data is not based on any comparable set of indicators or population totals; Bromley has one of the highest numbers of older people living within its borough.

2.17.2 The reporting of DTOC`s for the Princess Royal University Hospital (PRUH) is agreed between Hospital based and Social Care staff within the TOCB, and over which we have some control. The NHS England data includes this local data with that of the data reported to them by the Health Trusts over which we have less control.

2.17.3 Older people are more likely to be suffering with long standing chronic health conditions which compound their frailty and need for care:

- Complexity of cases – where it takes time to ascertain which pathway patients should be going down, which can change depending on medical status at the time. This also includes Section 42 safeguarding enquiries.

- Family disputes/family choice – LBB continue to offer one placement, which family will refuse if they are not happy with this choice. In some cases it is then the responsibility of the Trust to issue their eviction notice.

- High cost placements – e.g. 1-1 supervision requested by the care home which is funded from the 'Better Care Fund'. We continue to work closely with the CCG seeking their involvement with 4 week reviews & guidance on how the care staff can meet care needs and how they can manage challenging behaviour. We also require care homes to evidence how they are utilising the 1-1 funding.

- Delays in Community Equipment delivery and minor adaptations also contribute to the delays.

- CPT/Brokers continue to seek placements within the LBB ceiling rate for all care services including Double Handed care packages.

- We do not get the detail or the figures from the out of borough/ neighbouring hospitals as these are reported directly to the NHS England, hence it is difficult to challenge/argue these figures.

2.18 In addition, the Orpington beds have now opened and patients are often transferred into them without an assessment to determine the best pathway to be taken to facilitate a safe discharge from hospital.

2.19 This authority is a key partner within the health and social care economy, and staffs attend regular meetings/forums where the development of services and the infrastructure to support the system are discussed. We are currently working with the CCG, Hospitals and other partners to look at what additional support would be required to develop a Discharge to Assess model of care.