ONE BROMLEY

BROMLEY SERVICE DIRECTORY FOR ACUTE HOSPITAL SERVICES

SERVICE	HOW TO REFER/BOOK	DESCRIPTION	MORE INFORMATION
DISCHARGE PLANNING			
Transfer of Care Bureau (ToCB)	PRUH staff to refer to the ToCB via EPR Supported Discharge Referral or via DisCo/ Navigator at Board Round for help with any supported discharge ToCB **call ext 65442**	**ToCB will support with pathway decisions, case manage complex cases and provide specialist advice and support including:** • Referral and co-ordination of **new Package of care or Care Home Placements** • **Enhanced Care at home** – Live in care and night sits to support people with higher care and support needs for a maximum of 2 weeks as an alternative to care home admission • Discharge of **End of Life patients with complex care and support needs** • **Step Down Beds** – Interim community beds • **Deep cleans/Repairs** • **Out of Borough residents requiring care and support** • **Mental Health Flow Manager** Supporting discharges of patients with mental health needs • **Patient Transport ("DisCo Bus")** Dedicated Transport to prevent failed discharge for supported discharge patients.	
Single point of access (SPA) for supported discharge	SPA: **020 8315 8750**	**For access to all post-discharge health and social care support including:** • **District Nursing** • **Bromley Rehabilitation Services** comprised of Bromley Bed-based Rehab, Home Based Rehab, and Reablement • **Rapid Access to Therapy Team** to enable a rapid discharge with therapy needs assessed at home • **New or increased Package of Care** • **Fracture Pathway** – care and support for non-weight bearing or partial weight bearing patients.	Please have all information relating to the patient's current care and support needs, clinical presentation including medication, Covid status, and tissue viability available.
Proactive Care Pathway	Via request to GP in EDN or during SPA referral	Holistic assessment by community matron discussed via community MDT including Geriatrician for proactive care planning.	
Discharge support via community based services for vulnerable residents (Bromley Well)	Email **SPA@bromleywell.org.uk** or Tel: **0808 278 7898**	• **Take home and settle** patients taken home in a car by a Bromley well volunteer who will settle them at home • **Handy person service** fitting of rails, key safes, moving of furniture and other light repairs to enable hospital discharge • **Sitting Service** – 24/7 Monday to Saturday • **Frailty Care Navigator and 6 weeks Hospital Aftercare Service** for patients requiring short term assistance with escorting to appointments, basic shopping, befriending and more.	**www.bromleywell.org.uk**
Restart existing Package of Care	Use the restart checklist found on Kwiki > Transfer of Care Bureau > Restart	Any clinician can restart care using the restart checklist.	

SERVICE	HOW TO REFER/BOOK	DESCRIPTION	MORE INFORMATION
LOCAL AUTHORITY/SOCIAL CARE			
Adult Social Care	Mon-Fri 9am to 5pm via ToCB **Out of hours 020 8464 4848**		**https://www.bromley.gov.uk /info/100010/health_and_social_care**
Homelessness and housing advice (LBB)	Mon-Fri 8.45am to 5pm Tel: **020 8461 7721** **Out of hours 0300 303 8671**		**https://www.bromley.gov.uk /info/100007/housing**
COMMUNITY SERVICES			
Community health services	All community health care services referred via Single Point of Entry (SPE) form on EPR or call **020 8315 8722**	• Falls and Fracture Prevention • Community Neuro Rehab • Bladder and Bowl • Community Therapy (SLT, physio and OT) • Dietetics • Podiatry	For any queries on services or advice on appropriate pathways of care call the Bromley SPA to speak to a community clinician. **www.bromleyhealthcare.org.uk/ explore-our-services/medical-response-team/**
Community based rapid response (BHC)	Tel: **020 8315 8722**	Two hour or same day crisis response, 8am-8pm, seven days a week, from an advanced clinician to assess, treat, and arrange follow up in patient's own home – can be used for assessment follow up to avoid an admission.	**www.bromleyhealthcare.org.uk/ explore-our-services/medical-response-team/**
Community Intravenous Antibiotic Service (IV/AB)		Supporting people whose treatment is complete and only require a short course of IV/AB to return home sooner.	For any queries on services or advice on appropriate pathways of care call the Bromley SPA to speak to a community clinician.
Community Covid management Service (BHC)	Tel: **020 8285 6198**	Daily virtual monitoring of Covid+ patients and their symptoms.	For any queries on services or advice on appropriate pathways of care call the Bromley SPA to speak to a community clinician.
END OF LIFE CARE			
End of life and palliative care services (St Christopher's Hospice)	Email: **st.christophers@nhs.net** Tel: **020 8768 4500** **www.stchristophers.org.uk/ health-professionals/how-to-refer**	**Winter Turn Around Team** – Additional support for St Christopher's patients to care homes, ED and to support hospital discharge. **Bromley Community Palliative Care Service** – for people with advanced cancer and illnesses to remain at home and live well. **Living Well at Home Team** – using therapists and volunteers for those unable to attend outpatients.	**www.stchristophers.org.uk**
STROKE REHAB			
Stroke Rehab	Referral form at **www.lewishamandgreenwich.nhs.uk/ bromley-stroke-rehabilitation-team/**	**The Bromley stroke rehabilitation team** (BSRT) provides specialist stroke rehabilitation for patients in Bromley, either in their own homes, nursing homes or residential homes. Service includes Early Supported Discharge, Supported Discharge and Targeted Health Management Team.	
OTHER			
High Intensity User Service	Contact High Intensity Users Liaison Lead on **0777 381 0934** or **thomas.goromba@nhs.net**	Provides a de-medicalised approach to better meet the needs and reduce reliance on health services for people whose social circumstances may contribute to their frequent ED attendances.	