APPENDIX A

NHS Bromley Clinical Commissioning Group

BROMLEY WINTER PRESSURE REVIEW

1. Background

Bromley CCG funded enhanced and additional capacity across the system to ensure health services continued to meet demand over the winter period. The CCG funded £628,517k worth of winter activity across a range of services during the period which saw the highest activity levels in the history of the Bromley system. However performance throughout winter 2017/18, although not meeting national standards, was better than that of previous years with responsiveness and recovery rates considerably improving showing increased resilience across the system as a whole.

The report provides an overview of what was commissioned by the CCG, the impact, lessons learnt and recommendations going forward.

2. Outline Of Bromley CCG Winter Pressure Schemes and Spend

For winter 2017 Bromley CCG enhanced capacity across a range of health services including increased primary care capacity through additional GP appointments and home visiting service as well as end of life community care. A multidisciplinary front end team was put into the PRUH with access to urgent community support to prevent avoidable admissions and additional discharge co-ordinators to increasing timeliness, safety and quality of discharge for people on the supported discharge pathway.

The following table shows the detail of the what was commissioned and delivered

Provider		Grade	Unit cost (Oct-Mar)	WTE	Hours	17/18 Budget	17/18 Final Cos	18/19 Fin year
	Admission Avoidance							
Transfer of Care	DisCo	Band 6	£38,200	1		£38,200	£38,200	
Transfer of Care	Community Matron (backfill)	Band 8a	£50,250	1		£50,250	£50,250	
Transfer of Care	POC		£18	10	183	£98,550	£98,550	
Transfer of Care	Beds (1 block)		£610	1	183	£55,815	£55,815	
GP Allliance	GP support in TOC		£100	20		£48,000		
Greenbrooks	HCA's in Beckenham and the PRUH		£16,464	2		£32,928	£32,928	£10,976
Greenbrooks	GP Enhanced rates					£16,000	£16,000	
Greenbrooks	Patient Champion 7 days a week (both sites)					£18,702	£18,702	£6,234
	Patient Flow							
Transfer of Care	DisCo	Band 6	£38,200	2		£76,400	£76,400	
St Christopher	St Christopher's		£38,600			£38,600	£38,600	
St Christopher	St Christopher's Recruitment					£43,072	£43,072	
St Christopher	St Christophers (potential overspill)					£20,000		
	Primary Care							
GP Alliance	Additional appointments						£50,000	
BHC	Home visit service					£200,000	£100,000	£30,791
BCCG	Comms					£10,000	£10,000	
							£628,517	

3. Overview of Provision

Admission Avoidance

The total cost of schemes including those extended to the end of April is **£676,518**

4. Highlights

4.1 The following highlights were identified from each winter pressure funded scheme:

4.1.1 The Community Matron resource as part of the front end admission avoidance team was able to

- Enabled access to the Local Care Record and EMIs providing essential collateral histories (364 patients) on cases early which often changed the course of diagnostics or avoided admissions (260 patient) all together
- Identifying patients who presented as frail with no recent community involvement, frequent attenders or patients where there has been a significant change in their diagnosis and functioning to Community Matron colleagues as people who may benefit from an ICN review to prevent future admissions (8 patients)
- Having overview of all community health care services to advise in the most appropriate discharge plan, often having to use elements from several different services to initially facilitate the discharge, as a result over 40 early discharges were achieved
- Working alongside other organisations including St Christopher's to deliver safe and timely discharge for complex patients preventing readmissions with over 60 discharges supported by the in-reach community Matron
- Being able to flag patients who require urgent community follow up with community health colleagues to prevent possible readmission and support timely discharge.

4.1.2 Additional packages of care and emergency placement supported:

- Over 40 admissions were avoided due to availability of urgent support in the community
- Once up and running this formed part of the Discharge to Assess provision allowing earlier roll out for the front end

4.1.3 Additional Discharge Co-ordinator (DisCo) capacity provided:

- 45 Discharge to Assess (D2A) passports to facilitate D2A care packages/D2A beds which equates to 225 saved bed days
- Instrumental capacity in rolling out the D2A pathways and education of staff with regards to D2A

- Additional resource when the proportion of patients on supported discharge pathway rose to over 60% at times throughout the winter (ToCB commissioned for 20%)
- Additional resource to enable full time support to the front end of the hospital throughout the period

4.1.4 St Christopher's in-reach and additional community capacity:

- Having a skilled specialist onsite working alongside discharge co-ordinators to identify end of life patients supporting acute staff and managing the interface between the community and acute setting as a result 174 patients were identified of whom 120 (69%) were not previously known to any service at St Christopher's.
- Increased capacity (from 35 packages in October to 61 in January) in St Christopher's Personal Care Service (SCPCS) to allow for the increased number of referrals identified from the hospital throughout the period. A total of 121 patients spent 2306 days at home (99%) and 30 days in hospital (1%)
- The resource supported significant reduction in length of stay for EOL patients who are medically safe for transfer from 5 days to 1

4.1.5 Urgent Care Centre investment provided:

- Extended patient champion hours supported redirection and increased use of hub appointments including advise and sign-posting to reduce avoidance attendances
- Enhanced GP rates resulted in 100% rota fill across both sites including bank holidays and weekends enabling the UCCs to support ED and see as many patients as possible
- Valuable resource, across both sites including communication with patients and other professionals
- Increased Health Care Assistants allowed clinical staff to focus on treating and discharges more patients with HCAs completing ECGs, observations, plastering and some dressings
- Although urgent care centres saw a significant increase in attendances throughout winter, on the whole patients were seen in a timely manner

4.1.6 Increased GP access Hubs and home visits resulted in:

- Between 93-97% utilisation of appointments throughout the winter
- As of end of January 274 patients were visited in their own homes

4.2 Learning for Future Planning

- Increasing capacity within existing services worked better than previous winters when new provision has been introduced but not utilised
- Although a significant increase in attendance was seen, performance remained better than previous years including improved A&E performance and considerable reduction in Delayed Transfers of Care (DToC)

- Significant numbers of attendances continued throughout the winter – further work to better understand the reason and prevent attendances is required.
- Although all services offered were utilised and showed positive impact, significant numbers of people still required hospital based care, especially those with complex health and social care situations. Due to the complexity and demographic of patients further work is required to provide a more integrated community response to admission and attendance avoidance that is able to be accessed by a range of community providers including domiciliary care services and placements as well as the Emergency Department.

4.3 Recommendations

1. Earlier planning and mobilisation of schemes to allow for staff recruitment; and

2. Utilising existing service provision to develop an integrated urgent and emergency care system in the community providing a single point of access to a range of community services able to provide brief acute level interventions to support more people at home, preventing the need for hospital based care and support.