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DATE: 09 June 2011

ADULT AND COMMUNITY POLICY DEVELOPMENT AND SCRUTINY COMMITTEE

Meeting to be held on Tuesday 14 June 2011

Please see the attached report(s) marked "to follow" on the agenda.

6 **MINUTES OF THE MEETING OF ADULT AND COMMUNITY SERVICES PDS COMMITTEE MEETING HELD ON 29 MARCH 2011 AND THE JOINT MEETING WITH PUBLIC PROTECTION AND SAFETY COMMITTEE HELD ON 4TH APRIL 2011** (Pages 3 - 6)

Minutes of the joint meeting with Public Protection and Safety Committee held on 4th April 2011 attached for your information.

8 **STROKE SERVICES IN BROMLEY** (Pages 7 - 24)

Appendix attached for your information

9 **QUALITY, INNOVATION, PRODUCTIVITY AND PREVENTION (QIPP) PROGRAMME UPDATE** (Pages 25 - 30)

Copies of the documents referred to above can be obtained from www.bromley.gov.uk/meetings

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ADULT AND COMMUNITY POLICY DEVELOPMENT AND SCRUTINY COMMITTEE

Minutes of the meeting held at 6.00 pm on 4 April 2011

Present:

Councillor Judi Ellis (Chairman)
Councillor Roger Charsley (Vice-Chairman)
Councillors Reg Adams, Ruth Bennett, Peter Fookes, Diana MacMull, Charles Rideout and Diane Smith

Also Present:

Councillor Graham Arthur

106 APOLOGIES FOR ABSENCE AND NOTIFICATION OF ALTERNATE MEMBERS

Apologies were received from Councillor William Huntington-Thresher and Richard Lane.

107 DECLARATIONS OF INTEREST

Councillor Ellis declared a personal interest as her daughter worked for SLAM Councillor Charsley declared an interest as a Member of SLAM.

108 SLAM - LEARNING FROM ABSCONDING

Tom Fahey, Clinical Director Forensic Services of South London and Maudsley addressed the committee. He updated Members on developments and Improvements since the Trust last addressed the committee in March 2010.

The “Buddi” system, which the Trust commenced using in 2010 and which was outlined to members in March 2010 was working well. The system was used for patients with moderate to medium risk and also for higher risk patients. The system was a “state of the art” tracking device for use with mental health patients. It enabled the patient’s location to be indentified to within 50 yards. It recorded and time logged movements so it was possible to track a patient’s journey and timescale at any point during their leave. The devices were tamper proof and alerted the monitoring system of any attempt at removal.

Most patients had welcomed it but there were a few patients who had instructed lawyers as they felt it was against their Human Rights to be "monitored". The challenges were also about consent and SLAM lawyers were currently looking at the levels of consent that were needed. He added that it was in the patients' best interests and safety that the system was used.

Since the introduction there had been very few patients who had breached the conditions of their leave and due to the Systems GPS tracking staff were able to locate them quickly and they were escorted back to the hospital. In all cases the protocols agreed with Ward Councillors had been followed. The number of incidents occurring during leave form River House had halved since the introduction of the "Buddi". The numbers of "abscond" incidents had almost halved and the actual number of incidents had reduced by 80%.

The Chairman of the Public Protection and Safety Policy Development and Scrutiny Committee thanked the members of SLAM for attending the meeting and giving an update.

The Vice Chairman of the Public Protection and Safety Policy Development and Scrutiny Committee asked about the reference in the report that a management specialist was taking over the prosecution of cases. He asked if the CPS would still have the input. David Smith from the Metropolitan Police explained that there was a permanent CPS lawyer now based at Bromley Police Station but explained that there were few cases that would get to the prosecution stage.

When asked about the costs of the "Buddi" system, Slam explained it was £100 a moth to rent the units and £115,000 had been spent in the last year on technology and staff training.

Members raised concern about violence towards he public and also to themselves. Prof. Fahy explained that SLAM were building links with other services to scientifically evaluate the "Buddi" system. There had been improvements in the system such as portable charger.

SLAM was then asked about how they monitor patients' medication when they are on leave Prof. Fahy explained that most medication is given by a fortnightly injection. When patients were discharged they usually went into a hostel or supported living where their medications could be properly monitored.

Members raised concerns how and for how long the data of patients' movements was kept. Prof. Fahy responded that that the data was stored by the security company but was only kept for the duration the patient remained at the hospital.

The Chairman of the ACS Policy Development and Scrutiny Committee felt that, with the changes in the service, it would be interesting for her committee to have an opportunity to scrutinise the changes.

The Public Protection and Safety Policy Development and Scrutiny Committee Chairman asked about a visit by members to SLAM. He had tried to arrange a visit after SLAM attended in 2010 but it had not been arranged. Jill Locket stated that this would definitely be arranged and that the clerk would contact her to arrange a date.

The Public Protection and Safety Policy Development and Scrutiny Committee Chairman thanked SLAM for an excellent update report and requested a further update in 12 months time.

RESOLVED that the report is noted.

The Meeting ended at 6.32 pm

Chairman

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NHS

South London
Cardiac and Stroke Network

CQC REVIEW OF STROKE SERVICES 2011

SOUTH EAST LONDON ANALYSIS

This report summarises the results of the January 2011 CQC review of stroke services, focusing on the Primary Care Trusts in South East London (SEL).

This review looked at the pathway of care for patients with stroke (or transient ischaemic attack) and their carers from the point where they prepare to leave hospital through to long term care and support in the community.

London was described as showing 'below average performance' in this review.

Three PCTs in South East London were described as **'fair performing'** (NHS Lambeth, NHS Lewisham and NHS Southwark)

Three PCTs in South East London were described as **'least well performing'** (Bexley Care Trust, NHS Bromley and NHS Greenwich)

High level areas for potential improvement include:

- Early Supported Discharge and community rehab (provision, waiting times and capacity issues)
- Information provision
- Involvement in and provision of services for carers
- Stroke review processes

The most notable gaps for these services are in the outer South East London

Alice Jenner
Senior Project Manager
South London Cardiac and Stroke Network
February 2011

CQC Stroke Services Review[1] – Scope Of The Review

This review was aligned to PCT boundaries, and analysed the pathway of care for people with stroke (or TIA) and their carers from the point where people prepare to leave hospital through to long term care and support in the community. It looked at health and social care services and links to other relevant services, such as local support groups and services to support participation in community life after stroke.

CQC Stroke Services Review – Method

Multiple sources of information were used to inform the review approach. These included:

- Workshops with representatives from national patient groups
- Research into patient experiences of stroke services
- Research undertaken with 'hard to reach' groups
- Assessment framework developed in conjunction with external advisory group, using feedback from site visits

The assessment framework was aligned to the National Stroke Strategy[2] Quality Markers, and a set of 15 scored indicators was developed.

Table 1: The scored indicators for this review

Scored indicator	Quality Marker
Early supported discharge	10
Community-based services	13
Secondary prevention	13
TIA care and support	6
Support for participation in community life	15
Long-term outcomes of care	13
Services for carers	13
Meeting individuals' needs	13
Range of information provided	3
Signposting, coordination and personalisation	3
End of life care	11
Involvement in planning and monitoring	4
Management of transfer home	12
Reviews and assessments after transfer home	14
Working together	17

From CQC – Supporting Life After Stroke Review January 2011

[1] http://www.cqc.org.uk/reviewsandstudies/strokeservices.cfm
[2] National Stroke Strategy, Department of Health (2007)

In Context

Since the information was collected for this service review, there have been significant organisational changes relating to community service provision, as part of the Transforming Community Services[3] programme of work. These changes impact significantly on the structure of community services, and some posts in stroke teams are likely to be placed at risk or may face re-grading in the coming months.

Figure 1 below outlines the changes.

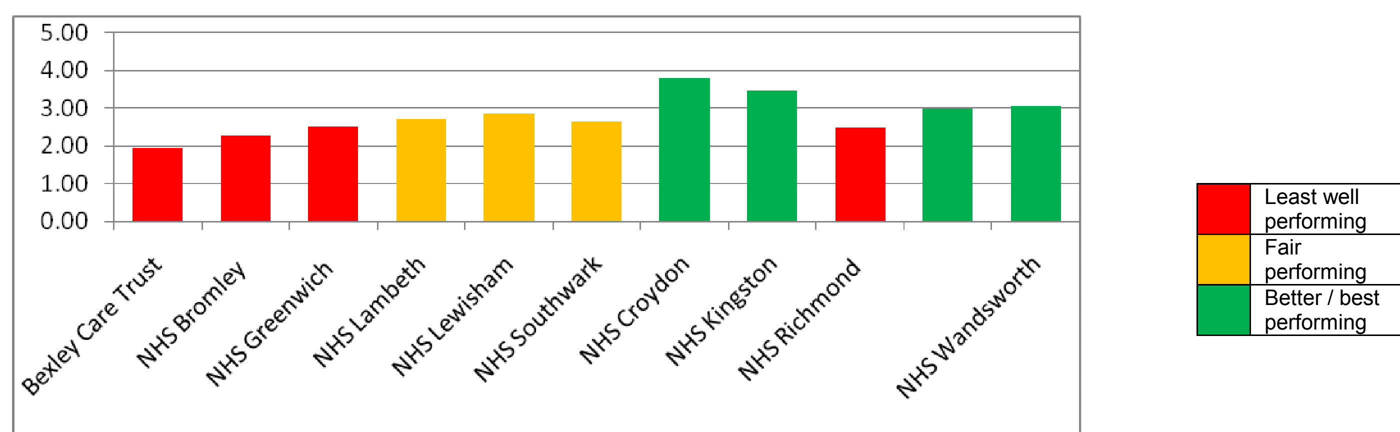
Figure 1

Borough	Planned / completed changes under TCS
Bexley	Integration of Bexley Community Health Services (main provider arm) with Oxleas NHS Foundation Trust.
Bromley	Bromley Healthcare (main provider arm) has become a social enterprise.
Greenwich	Integration of Greenwich Community Health Services with Oxleas NHS Foundation Trust.
Lambeth	Integration of Lambeth Community Health with Kings Health Partners.
Lewisham	Integration of Lewisham Healthcare with University Hospital Lewisham NHS Trust.
Southwark	Integration of Southwark Provider Services with Kings Health Partners.

This report summarises the data contained within the borough level CQC reports and seeks to put this in local context, and to aid the development of local action plans. The network team is aware of queries and concerns raised by some local providers and commissioners regarding the approach taken by the CQC in this report and accepts that, given the time elapsed since data was collected, some of the scoring may not accurately reflect the current situation regarding stroke service provision.

South London PCTs – Overall ratings and average scores

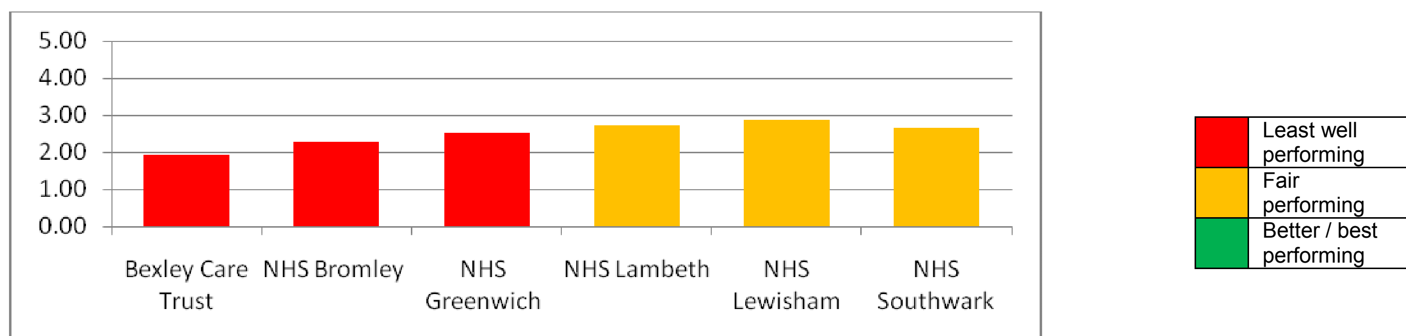
Information from a variety of sources was collated and reviewed to define an organisational score against each of the 15 indicators outlined earlier in this report. The scores from each indicator were analysed and weighted to provide an overall organisational performance score. Organisations were then ranked and rated according to the quartile correlating to their score. . RAG ratings have been added by the Network team to demonstrate variability in performance across the network area.



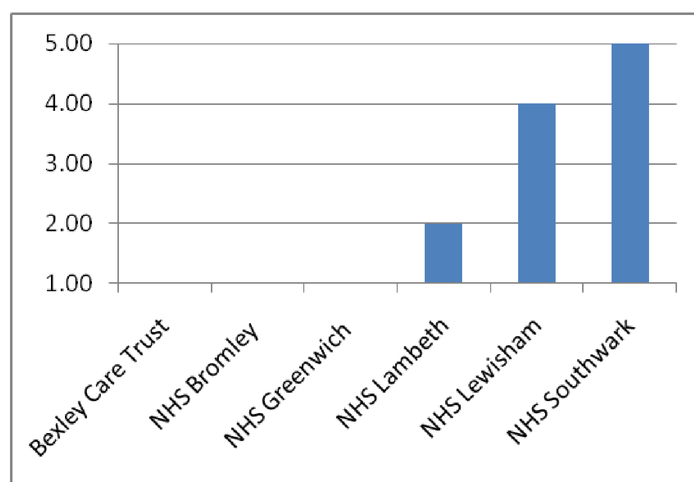
[3] http://www.dh.gov.uk/en/Healthcare/TCS/index.htm

South East London PCTs summary

Average scores



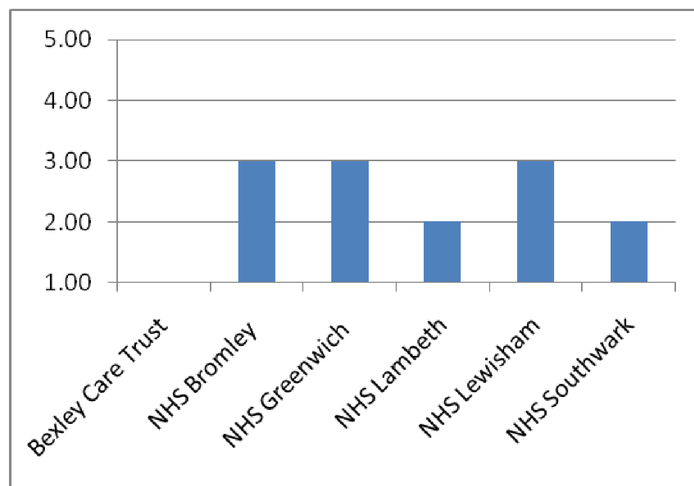
Early supported discharge



- The London stroke rehabilitation guide[4] advises that PCTs should seek to establish ESD services for eligible patients once community rehabilitation services are in place, reflecting its inclusion in the National Stroke Strategy.
- The absence of ESD services in some areas is impacting on Trusts' ability to discharge patients from Stroke Units (SUs).
- Bexley and Bromley have no ESD service at present.
- Bromley have concluded their procurement service for a neuro rehab service. The service, which will include stroke and possibly, at a later stage, an ESD service is expected to go live on 4th April 2011.
- Greenwich ESD service is not fully multidisciplinary (only includes physiotherapy, social work and rehab assistants) and there are capacity issues. A business case for ongoing funding is in development
- Lambeth and Southwark both have well established services. Lambeth appears to have scored lower due to lack of social work and dietetics input / access, and some staff have been described as not being stroke specialists. (This requires some clarification as we would expect similar outcomes in these boroughs).

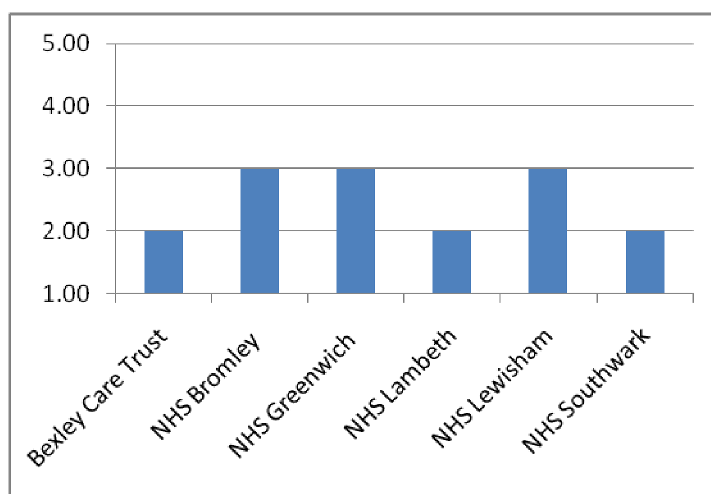
[4] Stroke rehabilitation guide: supporting London commissioners to commission quality services in 2010/11 (Healthcare for London; Commissioning Support for London)

Community based services



- Every PCT should commission a community rehab service for stroke patients, delivered by staff with stroke specialist skills. (according to London stroke rehabilitation guidelines)
- In Bexley there are significant gaps in access across the borough. Services in place are limited and not stroke specific.
- Bromley have concluded their procurement service for a neuro rehab service. The service is expected to go live on 4th April 2011.
- Lambeth in particular were noted to have very short waiting times. However in Greenwich and Lewisham there are long waits for some services (e.g. community physiotherapy in both areas, SLT in Lewisham).
- In Greenwich these services are non-recurrently funded by the borough, and therefore are vulnerable in the current climate.
- The London stroke standards[5] state that patients previously in work should be offered vocational rehabilitation (full target 80%, interim target 60%) yet Lewisham and Lambeth are the only boroughs who have indicated that they have vocational rehabilitation services.

Services for carers

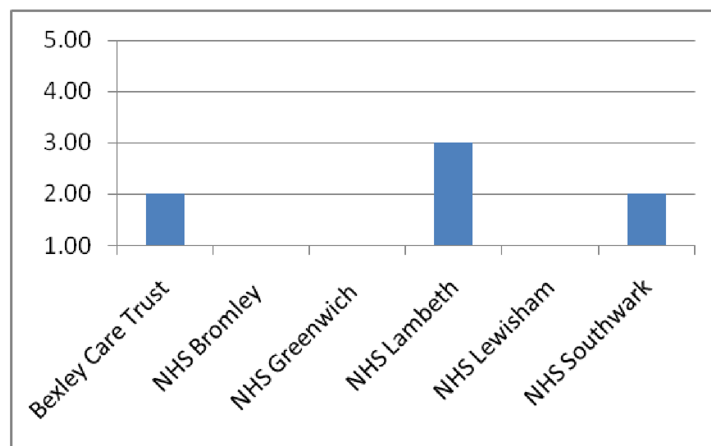


- Provision of information for carers is essential in helping people affected by stroke remain informed, included and supported as their needs change over time (QM3 National Stroke Strategy)
- Both Southwark and Greenwich were noted through this review as having the potential to make improvements in the information provided to carers regarding transfer home. The Network team will clarify current arrangements with providers, and work with them to improve information where required.

[5] The London Stroke Strategy (Healthcare for London; Commissioning Support for London 2008)

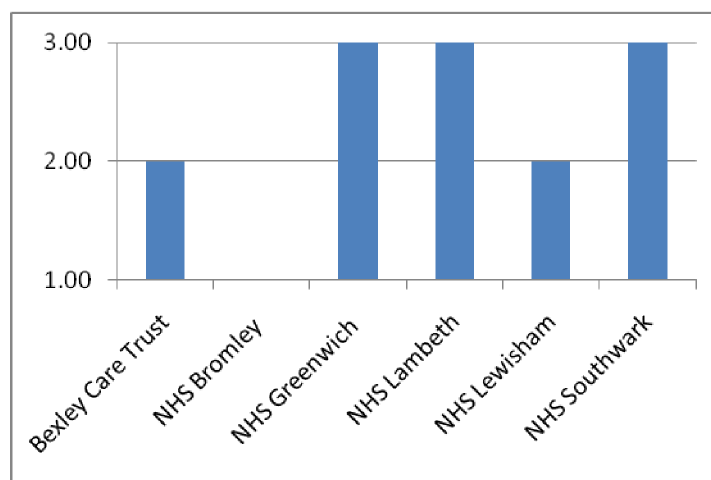
Secondary prevention

- Data from the QOF[6] (around blood pressure and cholesterol management) was used to inform this area. SEL boroughs scored relatively poorly on these.
- This information will be taken to the next South London (SL) Network Prevention meeting for review and discussion, along with relevant information from the stroke pathway profiles produced for each London borough by Commissioning Support for London[7] (CSL) in late 2010. It is envisaged that this group will lead on driving improvement across the SL region.



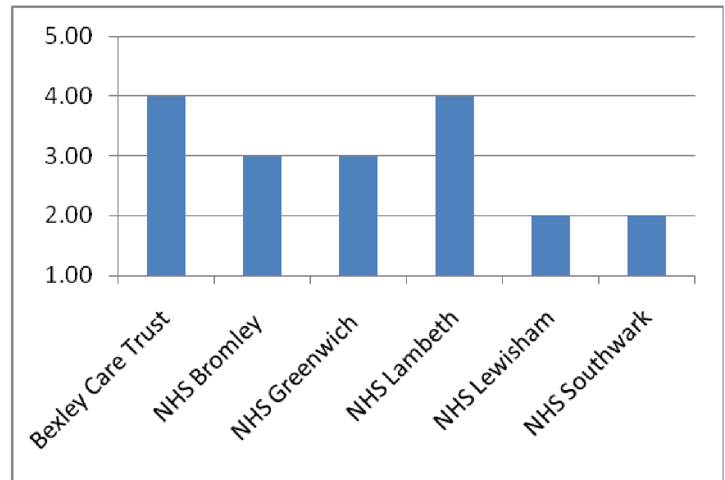
TIA care and support

- In London, people presenting with high risk TIA should receive a specialist assessment and treatment within 24 hours of symptom onset. For low risk TIA this should be within seven days. Specialist TIA services have been set up to help achieve this.
- Since this review was undertaken a TIA service at the Princess Royal University Hospital in Bromley has started (from November 2010)
- Since January 2011, the network has been receiving data from SLHT to help fully understand TIA service provision in Bromley and Greenwich.
- Services provided for Bexley and Greenwich patients have recently changed to QEH



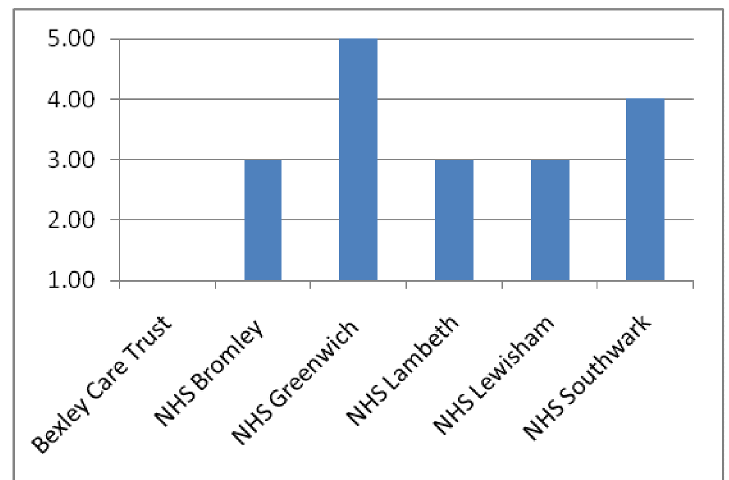
[6] www.gpcontract.co.uk
[7] http://www.csl.nhs.uk/Intelligence/Pages/PCTstrokeprofiles.aspx (2010)

Stroke end of life care



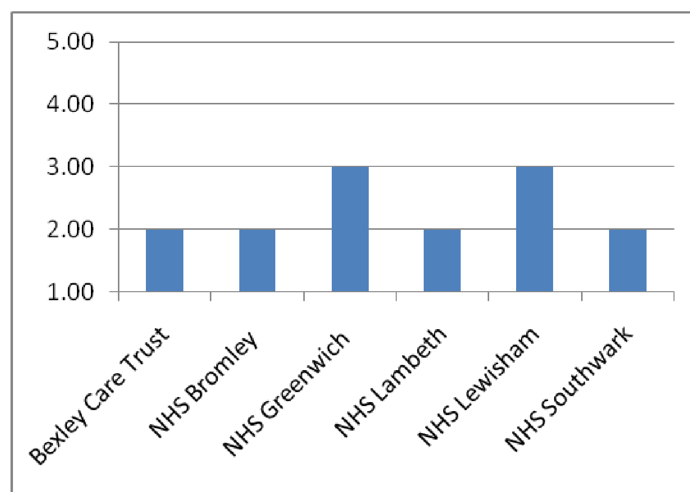
- QM11 of the National Stroke Strategy focuses on the need for end of life care that is delivered by appropriate professionals, and takes patients needs and wishes into account.
- Implementation of approaches, such as preferred place of care, the gold standards framework, and the Liverpool care pathway can be used to support patients through end of life care after stroke.
- Lewisham and Southwark have both indicated that end of life care services are not systematic (i.e. only 'some of' the PCT area is covered by these services).
- The Network team will work with providers and commissioners in these boroughs to look at current provision and how this might be improved.

Outcomes at year one



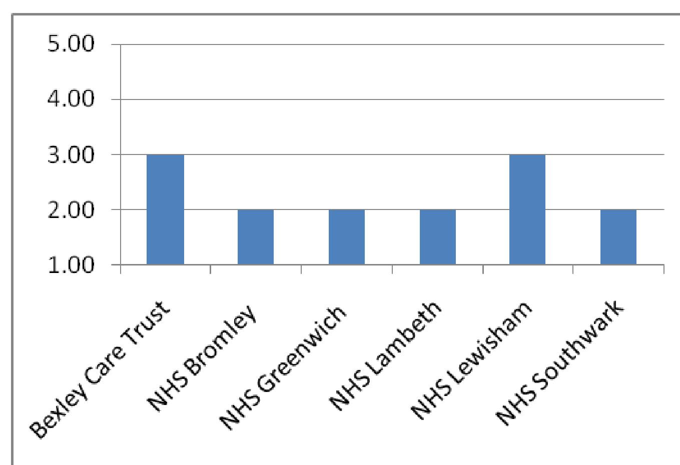
- Bexley scored markedly lower on this item. This is due to poor mortality rates following stroke in this area.
- The Network team will work with the Care Trust/public health team to look at these issues and how they could be addressed.

Meeting individual needs



- Equality impact assessments for stroke services do not appear to have been carried out in SEL.
- The Network team will clarify the status of these and flag this for action with relevant PCTs.
- Areas flagged as a national priority for improvement included:
- Ensuring services meet the needs of people with aphasia and other communication-related disabilities. In particular, social services appeared less aware of communication and other disabilities than they were for physical disabilities.
- Services could do more to understand and adapt to the needs people from particular ethnic or cultural backgrounds.
- Services for people in care homes may require review. Consideration should be given to training needs for care home staff.

Support for participation in community life



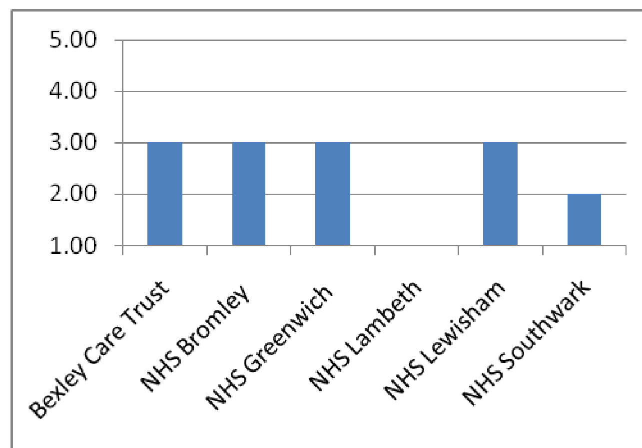
- The number of people with outcome focused goals varied. Lambeth and Southwark scored well in this area but in Bexley, Bromley and Greenwich they were <50%.
- Information on money and benefits was found to be an area for potential improvement. Interestingly, this was also flagged as a high priority at a patient and carer event run by the Network in July 2010. This should be incorporated into post stroke reviews.
- The London Life After Stroke Commissioning Guide (October 2010)[8] emphasised the importance of having person centred services to support stroke survivors to have a more positive engagement with their physical, personal and social environment. This includes providing information, addressing practical, emotional and financial matters that arise as a result of stroke. Commissioners are advised to focus on equity of access and on developing services that improve the quality of life of stroke survivors, including provision of information and opportunities for ongoing review, promotion of self management, increasing involvement in community life, and providing emotional support, and support for patients, carers and families.

[8] Life after stroke: commissioning guide (Commissioning Support for London 2010)

- A network project group, led by the voluntary sector and with involvement of social care, will be set up in FY2011/12 to focus on this area.

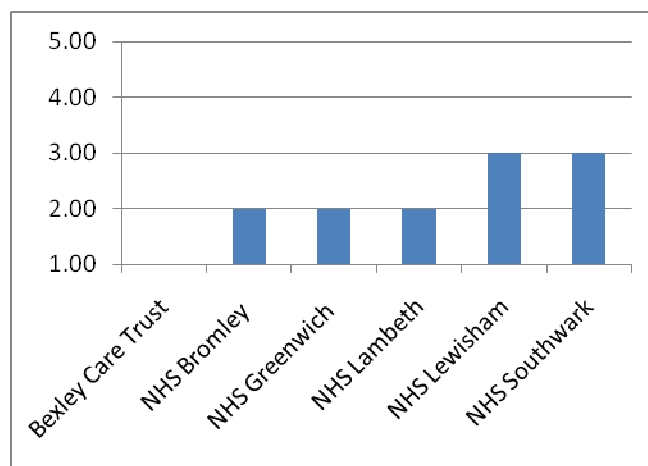
Range of information

- A local panel of patients and the public reviewed Patient information on transfer home
- Lambeth and Southwark were scored poorly by the panel with regard to the range of information available. This is unexpected given the Modernisation Initiative work completed, including a patient handbook. The Network team will seek further clarification from these boroughs regarding information provided via the South East London workstream groups.

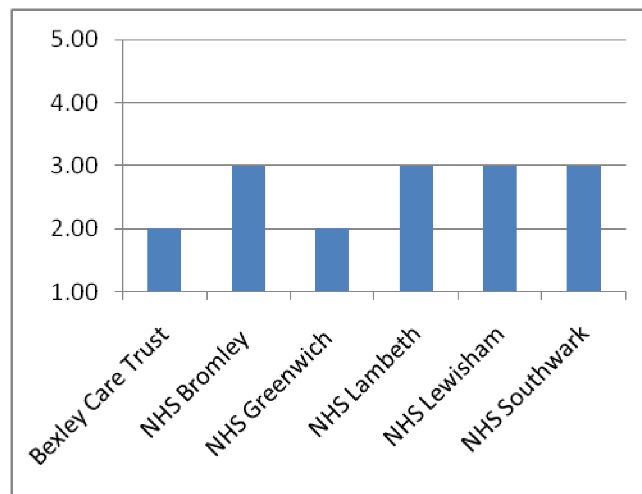


Signposting, coordination and personalization

- In Bexley, information was deemed neither easy to find nor understand. Less than 25% of patients had a named support worker.
- The London standard states that everyone who has had a stroke and their carers should have a key support worker such as a family support worker or community matron to provide:
- Longer-term support
- Navigation and advocacy
- A link with the inpatient and community rehabilitation teams and other care providers
- In Greenwich the information was also not easy to find or understand.
- Availability of helplines was variable across SEL. Where some of these are indicated to exist there is no information regarding their specific nature (e.g. provided by social care, level of support and info provided)

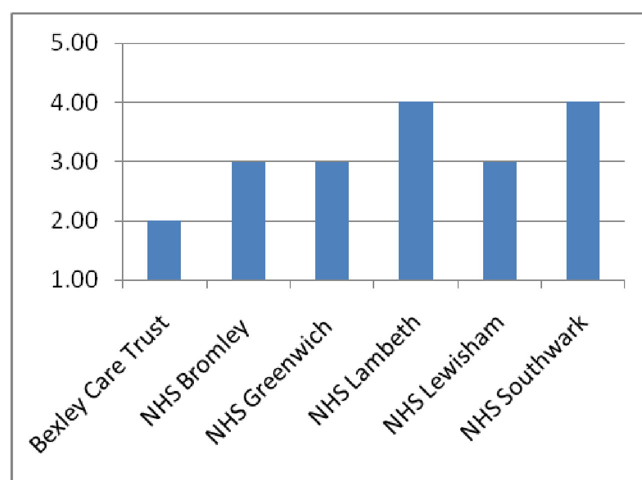


Involvement in planning and monitoring



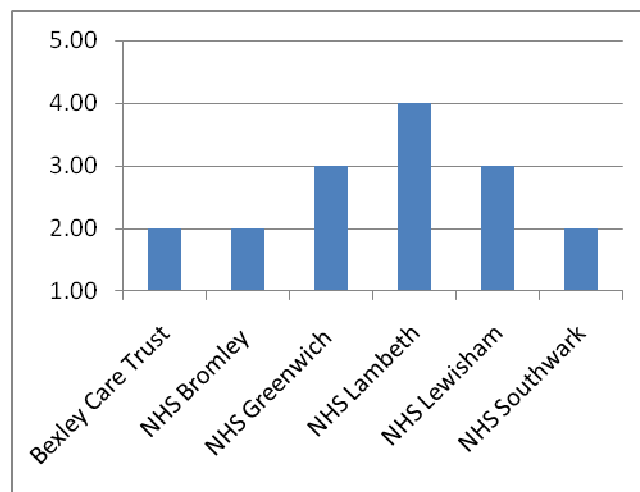
- In line with QM4 (National Stroke Strategy) the review looked at how patients and carers were involved in stroke services (e.g. focus groups, service design) and also at whether targeted approaches to involving specific populations were used (e.g. people with aphasia, people in care homes, people whose first language is not English).
- Bexley and Bromley scored poorly on their involvement of these target groups in stroke services.
- Both Lambeth and Lewisham lack targeted involvement for people in care homes.
- Greenwich indicated that there were no opportunities for carer involvement in stroke services.

Transfer home



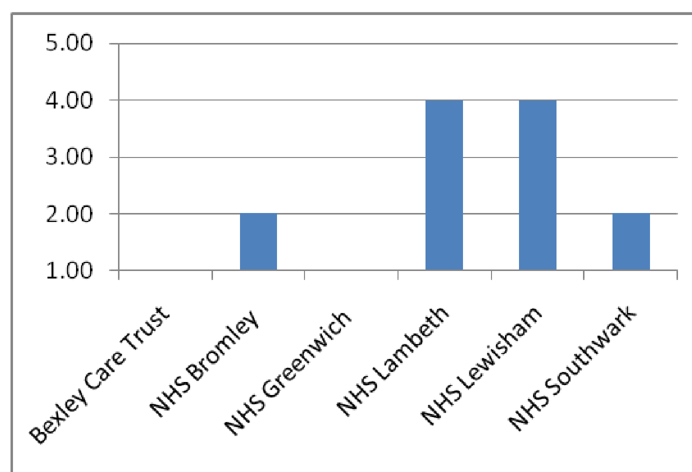
- In Bexley policies are in place for transfer home, but the content of these must be queried given the absence of a stroke team to look after these patients. These policies were not said to include patients being contacted within two days of transfer home.
- Policies in Bromley and Lewisham do not state that patients should receive copies of their discharge summaries
- In Bromley <40% of patients are contacted within two days of discharge. The London standard states that patients should be contacted by a member of the community rehabilitation team within 24 hours of discharge home, and should be assessed within three days. The network view is that monitoring timeliness of treatment is a better indication of quality of service and recommends monitoring of RC2 (percentage of appropriate patients whose treatment programme started within 24 hours (ESD intensity level) or seven days (non-ESD) of assessment) and RC7 (Percentage of appropriate patients receiving five sessions per week within the first two weeks (ESD), and/or three sessions per week for the first four weeks (non-ESD/post ESD) – of OT, PT & SLT. (Weeks start when treatment starts; ongoing to enable patients to meet goals)) from the London stroke rehabilitation standards.

Reviews



- Less than 50% of patients in Bexley have a care plan on discharge from hospital.
- In Bromley 90% of patients have a care plan, although it is unclear who is producing these given the lack of community service for stroke patients.
- Variable provision has been reported with regard to the six week review, but this appears to have excluded reviews provided by acute Trusts following discharge from hospital.
- There are significant gaps across SEL in the provision of six month and annual reviews.
- In Lambeth and Southwark a project is underway looking at how to implement post stroke reviews. This has been funded through a successful bid to the network for Accelerating Stroke Improvement (ASI) Programme[9] monies. The ASI programme has identified six month review in particular as an area identified for improvement.
- The Network is organising a task group meeting for March 2011 to look at the implementation of reviews in South London (focusing primarily on the six month review). This work continues from the Network's patient and carer involvement activities.

Working together



- Lewisham indicated that some integrated reviews of health and social care needs take place. It is unclear whether these reviews are facilitated by social work presence on the wards, or by integrated services. The Network team will follow this up with Lewisham for further information.
- No other borough in SEL indicated that these integrated reviews of health and social care needs occur.

[9] http://www.improvement.nhs.uk/stroke/AcceleratingStrokeImprovement/tabid/134/Default.aspx

Recommendations

Recommendation	Responsible Party	Network role
Continued focus on establishing / developing community rehabilitation stroke services with an integrated stroke supported discharge service (for those eligible for early supported discharge as well as those requiring ongoing community based rehabilitation following their inpatient stay), delivered by multidisciplinary staff with stroke specialist skills. Waiting times for these services should be monitored.	Local commissioners and providers	The network team will continue to support business case development where required. A service specification has been developed for use in South London, informed by national and local rehabilitation standards and guidance. This is in the process of being reviewed by members of the SL rehabilitation workstreams.
Vocational rehabilitation services should be available across all SE London boroughs.	Local commissioners	The network team will work with commissioners and providers to obtain further information regarding current provision and to highlight gaps in provision.
Service provision and information for carers should be reviewed	Local providers and commissioners	The network team will work with providers seeking to improve in this area and will share examples of good practice via network workstreams,
Review of QOF data on secondary prevention after stroke, along with relevant information from the stroke pathway profiles produced for each London borough in late 2010	Primary care	For review and discussion at the next meeting of the South London (SL) Network prevention group. It is envisaged that this group will lead on driving improvement across SL.
Continued development of TIA services	Local providers and commissioners	The network will continue to support the development and quality assurance of TIA services through the London assessment process and monitoring of Integrated Performance Measures for Stroke and TIA (previously known as vital signs).
Review current provision of end of life care for stroke and clarify areas for potential improvement.	Providers and commissioners (in Lewisham and Southwark in particular)	The network team will work with providers and commissioners to look at current provision of end of life care and how this might be improved.
Review issues behind poor mortality rates for stroke patients in Bexley.	Bexley commissioners	The network team will work with Bexley Care Trust/public health team to understand the issues and how they could be addressed.

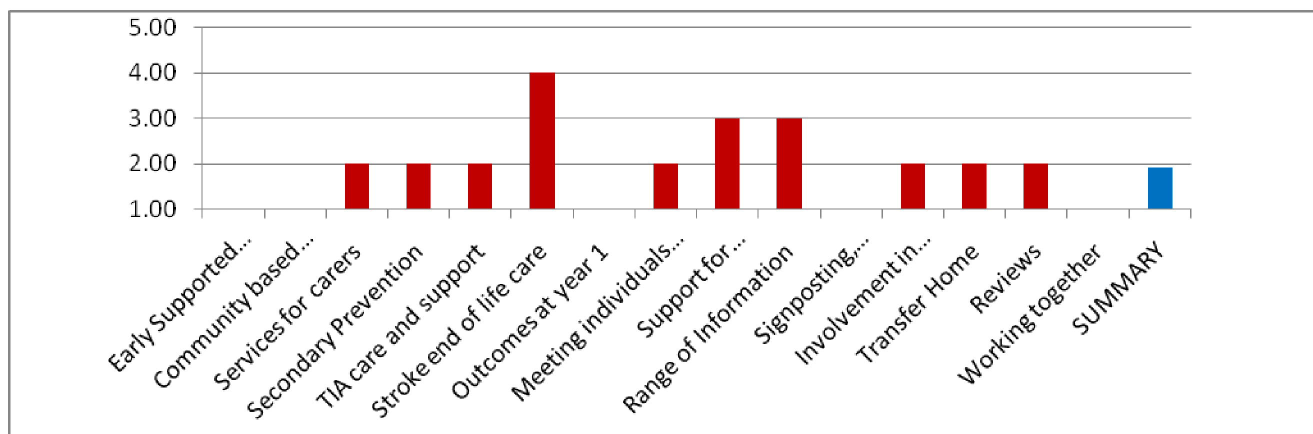
PCTs who have not yet completed Equality Impact Assessments for stroke services should seek to ensure these are undertaken.	PCTs	
Review of Life After Stroke service provision, guided by the London Life After Stroke Commissioning Guidance (2010).	Local commissioners	Current provision of Life After Stroke services in SE London should be reviewed by the network work group (to be established during FY2011/12) and examples of good practice should be shared.
Providers should review patient and carer information to make improvements flagged through their borough level reports and should involve patients and carers in further development of this information.	Providers	Examples of good practice can be shared through network workstreams for example the development of a stroke patient handbook for use in acute units and community settings.
All patients should be contacted within 24 hours of discharge in line with the London standard. The network view is that monitoring timeliness of treatment is a better indication of quality of service and recommends monitoring of two key standards from the London Stroke Rehabilitation Guidelines: RC2 (percentage of appropriate patients whose treatment programme started within 24 hours (ESD intensity level) or seven days (non-ESD) of assessment) RC7 (Percentage of appropriate patients receiving five sessions per week within the first two weeks (ESD), and/or three sessions per week for the first four weeks (non-ESD/post ESD) – of OT, PT & SLT. (Weeks start when treatment starts; ongoing to enable patients to meet goals))	Local commissioners and providers	
Acute providers should ensure patients are provided with a copy of their discharge summary.	Acute providers	

Delivery of post stroke reviews at 6 weeks, 6 months and 12 months (and annually after that).	Local commissioners and providers	The network stroke reviews task group will review the findings of this report to help map provision across SEL and develop action plans for improvement.
Patients should receive integrated reviews of their health and social care needs		The network team will seek to clarify arrangements for integrated reviews in Lewisham and share details of this via the rehabilitation workstream.

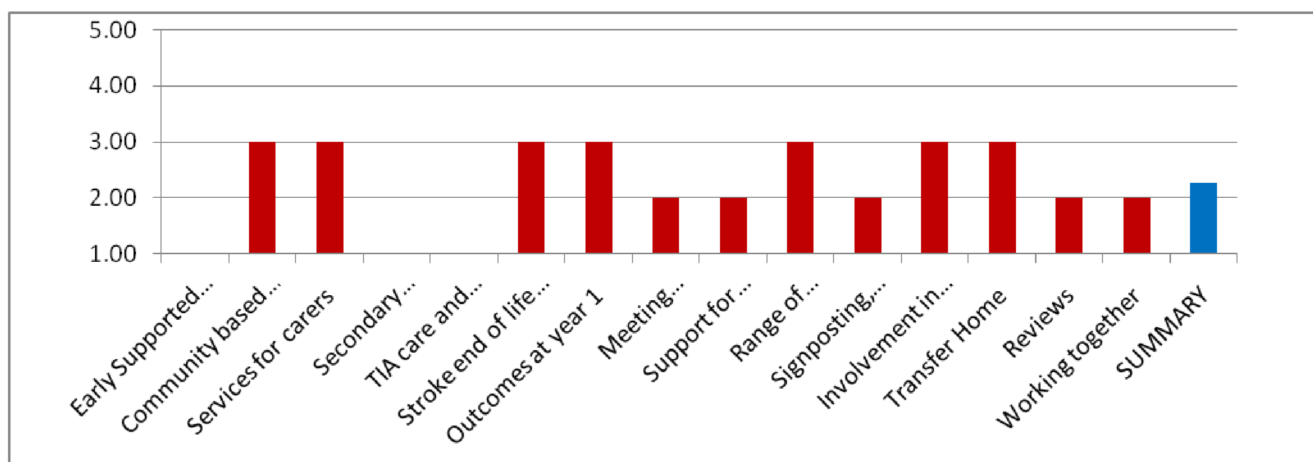
Appendix 1 - South East London – By PCT

**NB – the maximum possible score for TIA services was 3

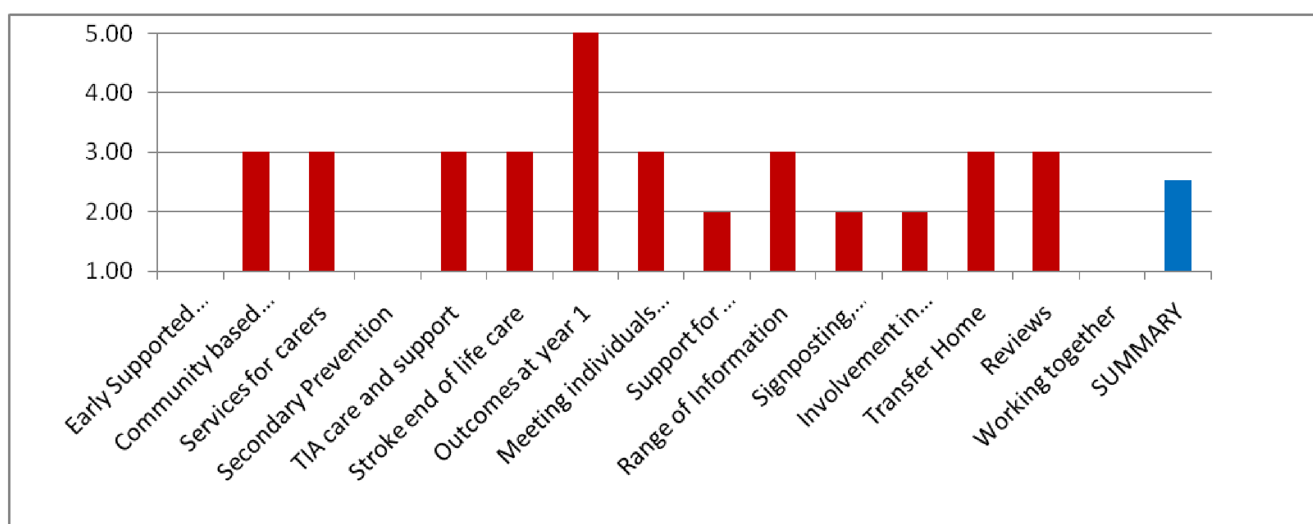
Bexley Care Trust



NHS Bromley



NHS Greenwich



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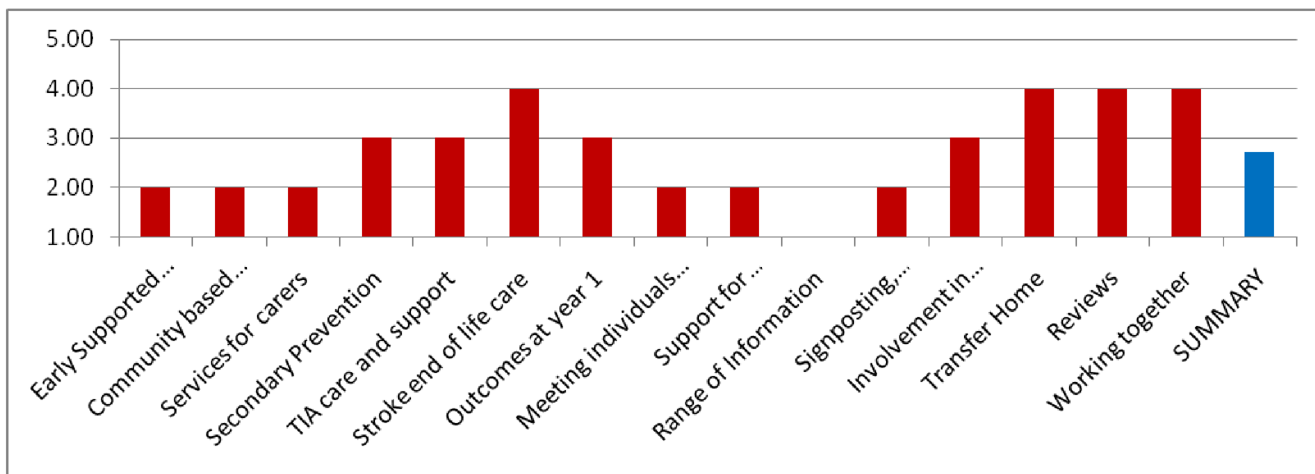

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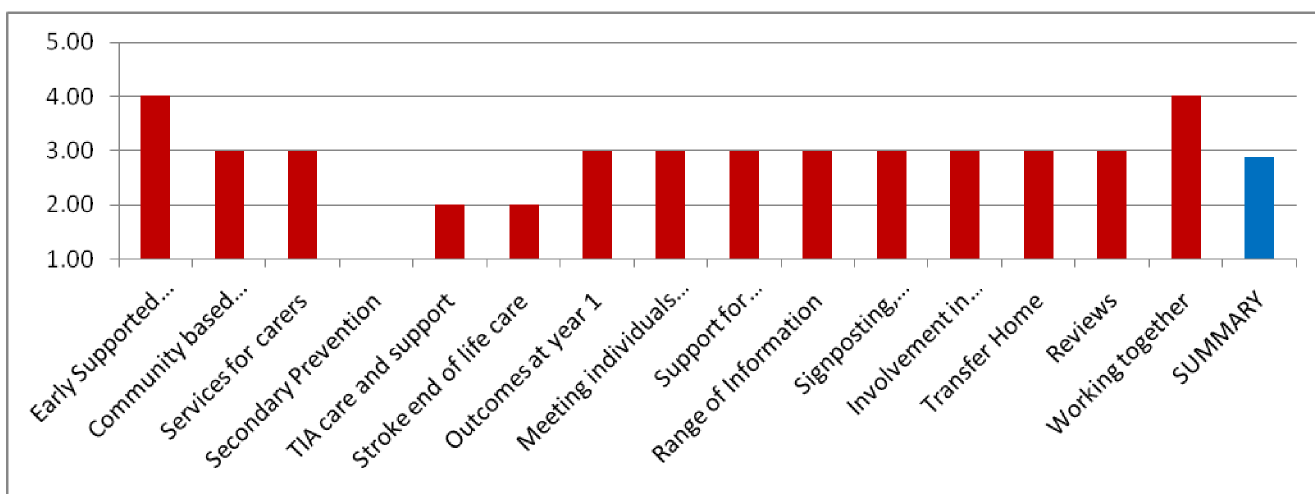

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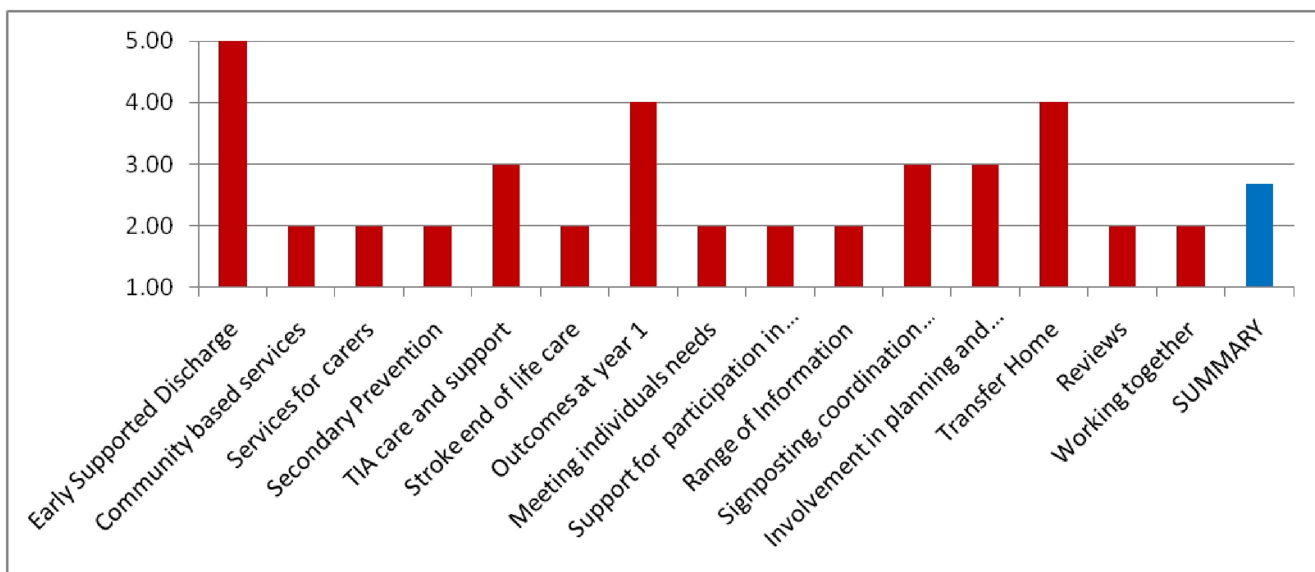

Appendix 2 – London borough ratings

NHS Barking and Dagenham	North East London Cardiovascular and Stroke Network	3.13	Better
NHS City and Hackney Teaching	North East London Cardiovascular and Stroke Network	3.00	Better
NHS Havering	North East London Cardiovascular and Stroke Network	2.60	LWP
NHS Newham	North East London Cardiovascular and Stroke Network	2.87	Fair
NHS Redbridge	North East London Cardiovascular and Stroke Network	2.87	Fair
NHS Tower Hamlets	North East London Cardiovascular and Stroke Network	3.13	Better
NHS Waltham Forest	North East London Cardiovascular and Stroke Network	2.40	LWP

NHS Barnet	North Central London Cardiac and Stroke Network	2.67	Fair
NHS Camden	North Central London Cardiac and Stroke Network	3.87	Best
NHS Enfield	North Central London Cardiac and Stroke Network	1.93	LWP
NHS Haringey	North Central London Cardiac and Stroke Network	3.80	Best
NHS Islington	North Central London Cardiac and Stroke Network	3.13	Better
Bexley Care Trust	South East London Cardiac and Stroke Network	1.93	LWP
NHS Bromley	South East London Cardiac and Stroke Network	2.27	LWP
NHS Greenwich	South East London Cardiac and Stroke Network	2.53	LWP
NHS Lambeth	South East London Cardiac and Stroke Network	2.73	Fair
NHS Lewisham	South East London Cardiac and Stroke Network	2.87	Fair
NHS Southwark	South East London Cardiac and Stroke Network	2.67	Fair

NHS Brent	North West London Cardiac and Stroke Network	2.53	LWP
NHS Ealing	North West London Cardiac and Stroke Network	2.60	LWP
NHS Hammersmith and Fulham	North West London Cardiac and Stroke Network	2.33	LWP
NHS Harrow	North West London Cardiac and Stroke Network	3.33	Best
NHS Hillingdon	North West London Cardiac and Stroke Network	2.67	Fair
NHS Hounslow	North West London Cardiac and Stroke Network	3.00	Better
NHS Kensington and Chelsea	North West London Cardiac and Stroke Network	2.93	Fair
NHS Westminster	North West London Cardiac and Stroke Network	2.27	LWP
NHS Croydon	South West London Cardiac and Stroke Network	3.80	Best
NHS Kingston	South West London Cardiac and Stroke Network	3.47	Best
NHS Richmond and Twickenham	South West London Cardiac and Stroke Network	2.47	LWP
NHS Sutton and Merton	South West London Cardiac and Stroke Network	3.00	Better
NHS Wandsworth	South West London Cardiac and Stroke Network	3.07	Better

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Report No.
RES11046

London Borough of Bromley

PART 1 - PUBLIC

Decision Maker:	**Adult and Community PDS Committee**
Date:	**14th June 2011**
Decision Type:	Non-Urgent Non-Executive Non-Key
Title:	**BROMLEY QUALITY, INNOVATION, PRODUCTIVITY AND PREVENTION (QIPP) PLAN**
Contact Officer:	Kerry Nicholls, Democratic Services Officer Tel: 020 8313 4602 E-mail: kerry.nicholls@bromley.gov.uk
Chief Officer:	Dr Angela Bhan, Joint DIrector of Public Health, MD Business Support Unit
Ward:	N/A

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1. <u>Reason for report</u>

1.1 Informing the Committee about the Quality Innovation, Productivity and Prevention Plan, developed by NHS Bromley

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2. RECOMMENDATION(S)

2.1 The Committee is asked to note this report, which is presented for information.

Corporate Policy

1. Policy Status: N/A

2. BBB Priority: N/A

Financial

1. Cost of proposal: N/A

2. Ongoing costs: N/A

3. Budget head/performance centre: N/A

4. Total current budget for this head: £ N/A

5. Source of funding: N/A

Staff

1. Number of staff (current and additional): N/A

2. If from existing staff resources, number of staff hours: N/A

Legal

1. Legal Requirement: See commentary below

2. Call-in: Call in is not applicable. PDS report

Customer Impact

1. Estimated number of users/beneficiaries (current and projected): Residents borough-wide

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Ward Councillor Views

1. Have Ward Councillors been asked for comments? N/A

2. Summary of Ward Councillors comments: N/A

3. COMMENTARY

1. Introduction

The QIPP plan replaces the old PCT Commissioning Strategy Plan and is designed to improve the quality of services as well as deliver value for money, and to reward innovation. However, it is not static and is continually changing and developing as opportunities to make improvements in quality and productivity are identified. The purpose of this report is to provide members with a summary update of both the progress with, and impact of, significant QIPP initiatives. It is not a completely comprehensive report, but focuses on those schemes that involve elements of service or care pathway redesign and identification a number of areas where NHS Bromley is actively seeking to expand QIPP initiatives. Other initiatives that are focused more on contractual variations and terms are not reported here.

2. Current QIPP Schemes

a. Musculo-skeletal Clinical Assessment and Treatment Service has been in operation across Bromley since September 2010. GPs are now able to refer via the Bromley Patient Referral Centre using bespoke referral forms to a clinical specialist. Within two days, the specialist reviews the referral for completeness and appropriateness before offering advice to the GP on management within primary care or signposting the referral to the most suitable clinical pathway which now includes enhanced and local high quality physiotherapy services. The benefits of the service in both quality and financial terms has been most significant: waits for adult MSK physiotherapy have reduced from 20 weeks plus to approximately four weeks; the demand for hospital appointments has decreased and patients and GPs have given overwhelmingly positive feedback about the service. The service has been supplemented by educational events for GPs to enhance their own skills in the diagnosis and management and of musculo-skeletal conditions. Plans to further enhance the services on offer to include direct access diagnostics and extended scope physiotherapy are being developed.

b. Gynaecology and Dermatology assessment and intermediate community services for the treatment of medically manageable conditions are in the advanced stages of procurement. It is hoped that patients will be offered access to the new services from July. GPs will refer via the Bromley Patient Referral Centre using bespoke referral forms to a clinical specialist who will review the referral for completeness and appropriateness before offering advice to the GP on management within primary care or signposting the referral to the most suitable clinical pathway. If intermediate or hospital services are deemed most suitable, the Patient Referral Centre will contact the patient to discuss their choice of provider before making an appointment that best meets their needs. The new service will operate out of suitable local premises offering appointments within four weeks of the initial referral thereby offering improved access and value for money with early diagnosis and treatment expected to lead to improved outcomes as a consequence.

c. Admissions avoidance – this a new service in operation since April of this year. It comprises a dedicated case-finding team who are based at the Princess Royal Hospital but are part of the community provider. Their role is to identify patients whose proposed admission could be avoided if a suitable care package for them could be put in place instead and to facilitate their safe return home with said care plan in place. The team also work in a similar way to effect the early safe discharge of patients from hospital. The benefits for patients of being cared for in their own homes are significant and well-documented, this is a value for money service and also enables the hospital to free up capacity for patients who absolutely need specialist care that only they can provide.

d. Chronic Obstructive Pulmonary Disease (COPD) community service – a specialist nurse and dedicated team originally piloted is now fully established in Bromley. The model of care that they provide has integrated well with local health services (EMdoc, Rapid Response, Community Matron Service, Primary and Secondary Care). The service provides care and support to patients living with COPD and helps them to develop a self management approach to their care, encouraging them to live independently and helping to reduce/avoid the need for hospital care, and also provides a Pulmonary Rehabilitation Service.

   Prior to this service being established there was no community-based service. Patients who required management over and above what is ordinarily available in Primary Care would only have had access to a hospital based model of care. There was no pulmonary rehabilitation provision available (which essentially empowers patients through health promotion and education to self manage their condition and live as independently as possible). All of the indicators locally (including data analysis of hospital activity and qualitative reporting) demonstrate that the service is making a significant difference to patients in Bromley living with COPD. A recent report for London found that the overall emergency COPD admission rate in Bromley is significantly lower than the national average. Bromley residents are almost three times less likely than residents in the local authority with the highest admission rate to be admitted for COPD. Once admitted for COPD, moreover, patients from Bromley spend significantly less time in hospital than other patients in England; over three days less than the local authority with the longest length of stay.

e. Specialist Neuro-rehabilitation service – this service is enabling patients recovering from significant neurological events and/or trauma to be transferred from out of area placements into the care and support of a newly established and local community based team that will help support the patient's rehabilitation in their own home. This ability to rehabilitate patients locally when previously they were placed in expensive facilities some distance from their own homes will make a significant difference to both patients and their families and is planned to form the basis for the further development of a local stroke rehabilitation team.

f. Ophthalmology Primary Eyecare Assessment and Referral Service (PEARS) – implementation of this new service is progressing well and it is expected that from July enhanced optometrists will be able to prioritise and manage patients presenting with a range of minor eye conditions in their practices. This will enable many patients to be seen quickly and treated safely and appropriately in local settings thus avoiding referrals to secondary care.

3 Improvement opportunities

a) Long term conditions (LTC)

We are actively seeking opportunities to focus on:

(1) Increasing the management of LTC in primary care, with a strong prevention element

(2) Re-commissioning alternatives to acute care in community settings

(3) Reducing unnecessary acute activity develop services closer to patients' homes and to ensure best possible use of hospital services

By working on these areas, we should able to achieve the following outcomes:

- Improved levels of health through primary, secondary and tertiary prevention. This includes many elements from smoking cessation to better rehabilitation
- Better coordinated care along agreed care pathways. Care is normally coordinated and integrated by the patient's doctors (GPs and specialists) to ensure holistic planning, delivery and access to any specialist expertise required.
- We need to further enhance a multi-disciplinary team approach within health services and with different agencies
- Reductions in emergency hospital admissions . With good disease management at primary care level, hospital activity for long term conditions can be significantly reduced.

Specific areas for focus will include:

- Multi-disciplinary managed care
- Specialist nurse interventions
- Discharge planning and post discharge support
- Active case management
- Specialist Nurses
- Telemedicine and telecare
- Early discharge planning and hospital-at-home
- Multi-disciplinary rehabilitation (e.g. pulmonary) for 6-12 weeks
- Active disease management
- Specialist primary care (GPwSIs)

b) <u>Maternity</u>

A number of initiatives to support increasing access to maternity services are already underway or are included in an action plan developed between SLHT and NHS Bromley. These include:

- Audit of women booking after 12 weeks 6 days – reasons why
- Re-design and re-launch of maternity booking form to capture where delays maybe taking place in the booking process
- Review of booking process at SLHT and increase capacity
- Reduce DNAs (non attendance)
- Increase access to ante natal care
- Communication strategy to reach key stakeholders: hard to reach groups; GPs, clinical staff etc

NHS Bromley is working with SLHT on a number of further improvements:

- fully adopting NICE guidance for normal, non complex, ante natal care
- increase the number of home births from 4% to 7%.
- Improving breastfeeding rates
- Reducing elective caesarean section rates,
- Improving choice for women. The new MLU units in QEH and PRU are able to increase choice of delivery for women, with PRU reporting over 40% of their midwifery-led births being water births since the opening of the new unit.

c) **<u>Mental Health</u>**

Oxleas provides a wide range of health and social care services and specialises in caring for people with mental health problems and learning disabilities. They have been the main provider of specialist mental health care in Bexley, Bromley and Greenwich for more than 10 years and

have developed a comprehensive portfolio of services in community and hospital settings. Oxleas provides adult learning disability services across Bexley, Bromley and Greenwich as well as forensic mental health care across south east London and to HMP Belmarsh.

Key issues related to mental health provision locally include:

- High occupancy rates on female medical wards resulting in placements outside borough for inpatient care
- The need to redesign the care pathway to provide services that support alternatives to hospital admission or specialist services
- Lower level of access to psychological therapies for men and BME communities
- Improve patient satisfaction rates
- High levels of spend in mental health services, e.g. mentally disordered offenders and acute specialist services
- The high number of people with dementia who are never given a formal diagnosis and as a result do not get the information, support and care they need. This often results in crisis management and over reliance on long term residential care
- Variability in the quality of Adult Mental Health services across primary care and secondary care

NHS Bromley is focused on the implementation of enhanced primary care based services designed to support patients to remain independent and effectively functioning, in line with London-wide and national IAPT strategy. Required outcomes include: increased choice in therapy interventions available, reduced inequality of provision within the Borough, improved psychological well-being, some resource targeted to vulnerable members of the community and support for people to return to work or retain employment.

Closer integration of mental health services within the community and with the local authority is essential, recognizing the need for more effective commissioning of secure services on a pan Borough basis. The IAPT scheme provides the opportunity for effective intervention at a local level in line with NICE guidelines for anxiety and depression, and supports patients to remain independent and effectively functioning.

4 Conclusion

As previously stated, the above is a summary of those initiatives that have involved service development and/or care pathway redesign and examples of where are seeking to enhance productivity and quality. Other initiatives of note not covered in this report, include the Urgent Care Centre pilots providing a safe and cost effective alternative to traditional non-blue light A&E attenders that have greatly reduced A&E attendances; plans to redesign intermediate care services to help avoid inappropriate hospital admissions; primary care education, engagement and training initiatives aiming to enhance the abilities and confidence of primary care practitioners to safely manager patients who they might otherwise have referred in the past.

If members are interested in more detailed reports about any of the schemes summarised above these can of course be made available on request.

Non-Applicable Sections:	Policy, Financial, Legal, Personnel Implications
Background Documents: (Access via Contact Officer)	[Title of document and date]