BROMLEY CIVIC CENTRE, STOCKWELL CLOSE, BROMLEY BRI 3UH

THE LONDON BOROUGH
www.bromley.gov.uk

TELEPHONE: 020 8464 3333 CONTACT: Helen Long
helen.long@bromley.gov.uk

DIRECT LINE: 020 8313 4595
FAX: 020 8290 0608 DATE: 21 January 2014

To: Members of the
HEALTH SCRUTINY SUB-COMMITTEE

Councillor Pauline Tunnicliffe (Chairman)

Councillors Reg Adams, Ruth Bennett, Roger Charsley, John Getgood, David Jefferys, Mrs Anne Manning, Catherine Rideout and Charles Rideout

Non-Voting Co-opted Members

Brebner Anderson, Disability Voice Bromley
Angela Clayton-Turner, Bromley Mental Health Forum
Linda Gabriel, Healthwatch Bromley
Brian James, Learning Disability Representative
Leslie Marks, Bromley Council on Ageing
Lynne Powrie, Carers Bromley

A meeting of the Health Scrutiny Sub-Committee will be held at Bromley Civic Centre on **THURSDAY 30 JANUARY 2014 AT 3.30 PM** *

***Please note Earlier Start time**

MARK BOWEN
Director of Corporate Services

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

A G E N D A

1 APOLOGIES FOR ABSENCE AND NOTIFICATION OF SUBSTITUTE MEMBERS

2 URGENT CARE - PRINCESS ROYAL UNIVERSITY HOSPITAL (Pages 3 - 12)

Please note that for consideration of this item the committee will be joined by Health and Wellbeing Board Members. After consideration the Board members will leave and the committee will continue with its agenda.

This item will include:

- Winter Pressures Update;
- Outcome of the meeting with Monitor in November;
- Outcome of the recent CQC inspection;
- Joint working to improve outcomes;

3 DECLARATIONS OF INTEREST

4 QUESTIONS FROM COUNCILLORS AND MEMBERS OF THE PUBLIC ATTENDING THE MEETING

In accordance with the Council's Constitution, questions to this Committee must be received in writing 4 working days before the date of the meeting. Therefore please ensure questions are received by the Democratic Services Team by 5pm on Friday 24th January 2014.

5 MINUTES OF THE MEETING OF HEALTH SCRUTINY SUB-COMMITTEE HELD ON 14TH OCTOBER 2013 (Pages 13 - 18)

6 MATTERS ARISING FROM PREVIOUS MEETINGS

7 PROMISE PROGRAMME (Pages 19 - 28)

8 LOCAL GOVERNMENT ACT 1972 AS AMENDED BY THE LOCAL GOVERNMENT (ACCESS TO INFORMATION) (VARIATION) ORDER 2006 AND THE FREEDOM OF INFORMATION ACT 2000

The Chairman to move that the Press and public be excluded during consideration of the items of business listed below as it is likely in view of the nature of the business to be transacted or the nature of the proceedings that if members of the Press and public were present there would be disclosure to them of exempt information.

Items of Business	**Schedule 12A Description**
9 EXEMPT MINUTES OF THE MEETING HELD ON 14TH OCTOBER 2013 (Pages 29 - 30)	Information relating to the financial or business affairs of any particular person (including the authority holding that information)

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Report No.
CS14020

London Borough of Bromley

PART ONE - PUBLIC

HEALTH AND WELLBEING BOARD
Care Services PDS - Health Scrutiny Committee

Date: **Thursday 26 September 2013**

Report Title: **A&E PERFORMANCE AT PRUH BRIEFING PAPER**

Report Author: Dr Angela Bhan Bromley Clinical Commissioning Group
Rey Aziz Corporate Governance Bromley Clinical Commissioning Group
Tel: 01689 866530
E-mail: angela.bhan@bromleyccg.nhs.uk rey.aziz@nhs.net

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1. SUMMARY

A&E performance at the PRUH over the last quarter has been at levels below the agreed performance level, with some very significant daily and weekly fluctuations.

There are various steps in place to help improve the performance in order that it is brought back in line with the agreed trajectory. This briefing paper outlines broadly the position in line with the trajectory in the previous quarter, highlighting some of the causes for the decline in performance in the previous quarter as well as describing current and planned actions.

2. REASON FOR REPORT GOING TO HEALTH & WELLBEING BOARD & CARE SERVICES PDS HEALTH SCRUTINY MEETING

Members of the HWB and Care Services PDS Health Scrutiny Committee are asked to note and comment on the actions that are planned and currently in progress.

3. SPECIFIC ACTION REQUIRED BY HEALTH & WELLBEING BOARD AND ITS CONSITUTENT PARTNER ORGANISATIONS

Bromley CCG and Kings College Hospital Foundation Trust working collaboratively with key NHS stakeholders will be responsible for ensuring all actions stated are undertaken and the commitment to returning to the agreed performance levels are attained.

Health & Wellbeing Strategy

1. Related priority: Diabetes, Hypertension, Obesity, Anxiety & Depression, Children with Complex Needs and Disabilities, Children with Mental & Emotional Health Problems, Children Referred to Children's Social Care, Dementia, Supporting Carers, Not applicable

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Financial

N/A

Supporting Public Health Outcome Indicator(s)

N/A

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4. COMMENTARY

Please see attached report for details

Non-Applicable Sections:	Financial, Legal and Governance implications Comment from the Director of Public Health
Background Documents: (Access via Contact Officer)	[Title of document and date]

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A&E PERFORMANCE AT PRUH BRIEFING PAPER

1. Background

The national four hour wait target requires A&E departments to see 95% of attending patients within four hours of their arrival at A&E. Although ostensibly an A&E waiting time target, this standard is regarded as a health and care economy measure. All agencies, commissioners and providers, including local authorities, are expected to work with hospitals to share the common responsibility of ensuring the target is met. This approach is continuing now with King's College Hospital (KCH) having taken over the Princess Royal University Hospital (PRUH) from October 2013.

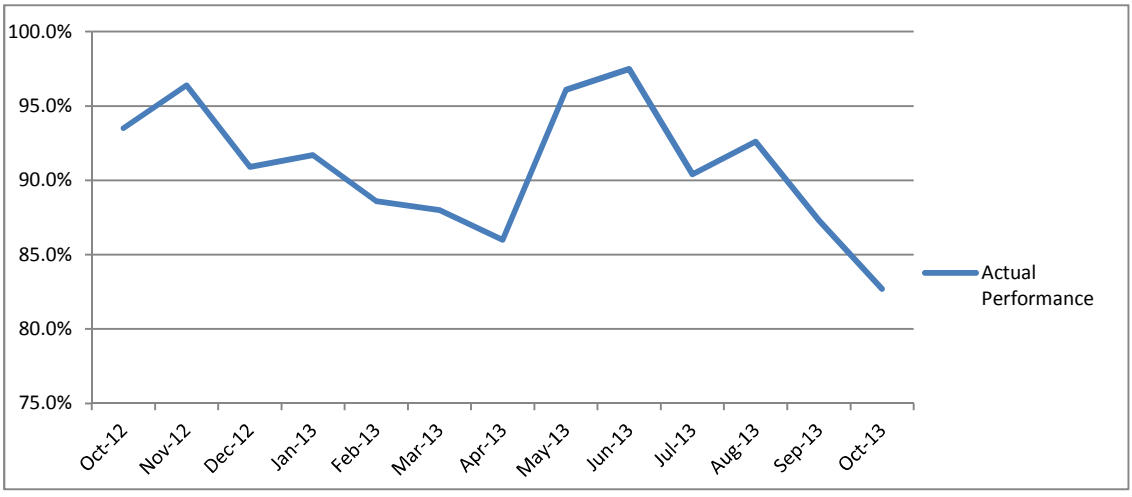
Locally in Bromley, the 4 hour A&E target has often been a challenge in recent years, but the whole health and social care economy has worked together to support the target, and it has often been possible to pull performance back to good levels. In recent months, the reconfiguration of acute services in South East London has seen some concurrent reductions in delivery of the 4 hour target.

For the purposes of measurement and comparison, patients attending A&E are divided into three categories – type 1, 2 and 3. Type 1 patients are the most severely ill and type 3 patients are the ones that might normally be seen and managed in the Urgent Care Centre.

Because of the challenges associated with taking over the PRUH, the CCG agreed with King's, a performance trajectory of 87% average (all types) for Quarter 3 and 90% (all types) for Quarter 4 of 2013/14. This was also agreed with Monitor and NHS England (London) as a realistic trajectory. Commissioners would ideally have preferred a trajectory that delivered a higher level of performance, but given the trend during Q2 and the change in management and staffing immediately prior to October, a more ambitious target was felt to be unrealistic.

Graph 1

The graph below covering the period October 2012 to October 2013 demonstrates the overall downward trend in performance.



2. Urgent Care Facilities in Bromley

A number of services are in place to help patients who need urgent health care, both in and out of hours.

In Bromley, the main A&E department is located at the Princess Royal Hospital in Locksbottom and is co-located with an Urgent Care Centre. Once a patient enters the building, they are streamed by a senior nurse to A&E or Urgent Care. In the A&E department, there is a triage nurse who can start investigation and treatment if necessary. There is another urgent care facility at Beckenham Beacon. Surrounding A&E departments include those in Lewisham, Greenwich and Croydon, with an Urgent Care Centre at Queen Mary's Sidcup.

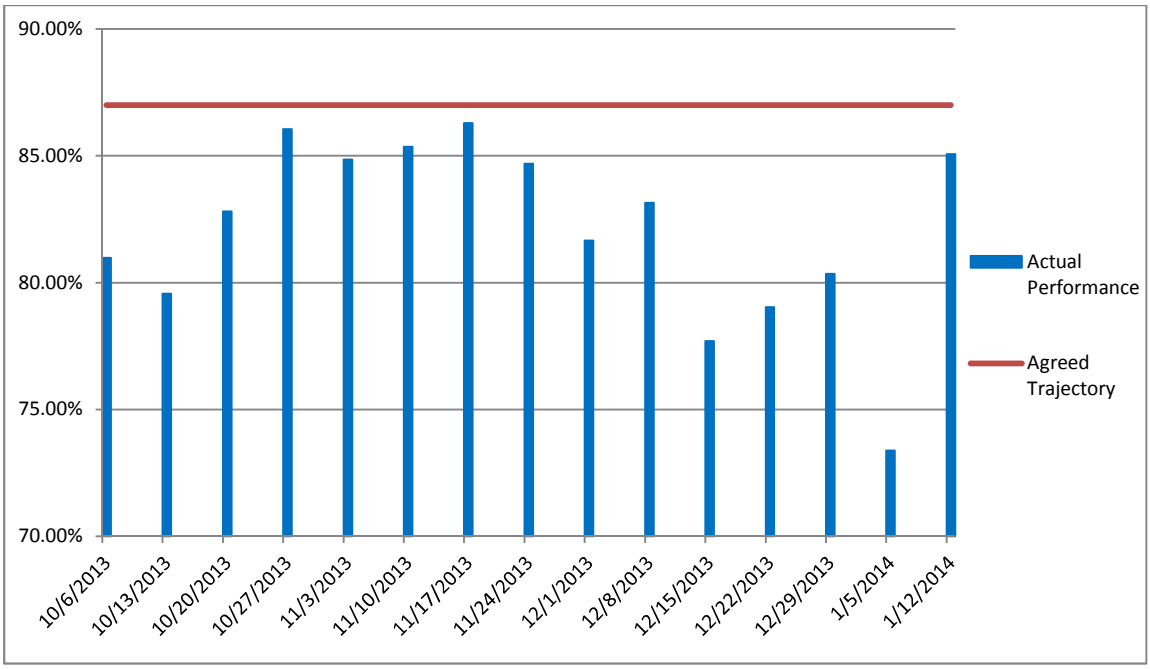
In addition to this, GPs are expected to see patients registered with them on an urgent basis according to need, within surgery hours. An out of hospital GP service is available and accessed through the 111 service which also provides telephone advice on health problems.

3. Summary of Current Performance

Performance for Q3 year to date was at an average of 82.5% for all type attendances with some very significant daily and weekly fluctuations. Graph 2 gives the weekly performance from the beginning of October 2013.

Graph 2

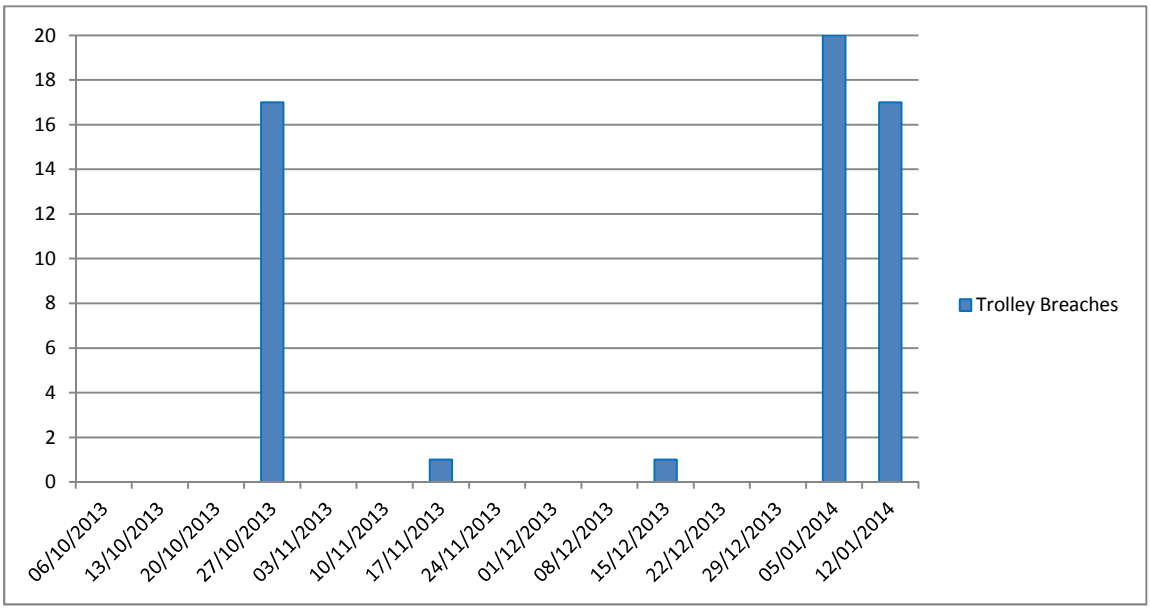
The graph below illustrates performance in Q3 leading into Q4 against the jointly agreed trajectory.



Fluctuations in performance over early January culminated in a number of 12 hour trolley breaches as demonstrated in graph 3. There were also a number of 12 hour breaches in October.

Graph 3

Weekly 12 hour trolley breaches taking place at the PRUH during Q3 entering into the first week of Q4.



KCH colleagues have undertaken detailed analyses for the reasons for the significant number of breaches; this includes a detailed root cause analysis and action planning to ensure lessons are learned and the likelihood of such occurrences occurring again are reduced.

4. Factors for Challenging Performance

The following factors are responsible for the challenged performance at the PRUH:

- Reduced staffing establishment, as a result of staff changing jobs or leaving during the three month period leading up to KCH acquisition, and prior to the changes taking place (and even before the acquisition was agreed). This was probably as a result of uncertainty about the future within South London Healthcare Trust (SLHT) during that time. KCH is has recruited a number of new staff and is in the process of recruiting more. Some temporary staff have also been recruited to meet some of the staffing challenges.

- Over the months prior to the acquisition, there had been some reduction in the cohesion of some patient pathways; these will take some time to re-organise and improve.

- Improved reporting systems since KCH took over the PRUH have helped give a clearer picture of the patient pathways in the ED.

- Changes in the use of other local facilities that were part of the SLHT that enabled some patients to be treated elsewhere, for example some inpatient surgery at Queen Mary's Sidcup.

- Interface issues that have arisen partly as a result of transition, and partly because of new services being put in place. Actions are being taken to ensure that all agencies work together at all levels for the benefit of local patients

5. Actions to Improve local systems

All agencies are working on a whole system and collaborative basis to improve patient pathways in A&E, in terms of enhancing quality, ensuring safety and improving performance of the 4 hour target. A multi-agency A&E Recovery and Improvement Plan has been developed for 2014/15. Senior leadership from all agencies are committed to, and greatly involved in, the drive for improvement. Joint ownership has been taken of the issues and the need to achieve the performance targets.

Plans are constantly being reviewed and key actions fall under the following key categories:

- **ED Recovery and Improvement Plan**
  - Will contribute to both sustained A&E performance but also a high quality emergency care service at the PRUH.

- **Winter Plan**
  - Winter monies funded schemes for the PRUH will have an impact on performance over this winter.

- **Out of hospital investment**
  - Addressing key historic pressure points and ensuring appropriate utilisation of A&E and hospital services

Commitment across the health economy is further illustrated in the following actions that have already been taken:

- Re-commissioning of Intermediate Care Beds providing enhanced step down intermediate care services
- Re-commissioning of the PRUH Urgent Care Centre (UCC) which will enable enhanced and coordinated UCC and primary care out of hours. There has also been the provision for additional GP sessions in the UCC.
- A new step up community based service which is a combination of Rapid Response services and former intermediate care services.

- PACE (Post Acute Care Enablement) is facilitating the discharge of additional patients from the hospital on a daily basis, by providing enhanced support to patients in their own homes.
- Additional equipment and staff to install equipment are in position to enable all necessary modifications to be made to a patient's home to allow a more rapid and easy discharge. This has helped to support the independence of patients.
- There is additional staffing capacity in social care in order to provide emergency interim care, facilitate discharge of patients who are medically stable but have not been able to be discharged for non-clinical reasons.
- Implementation of new senior leadership team for the PRUH site to enable strong hospital management and clinical leadership.
- The introduction of additional nursing shifts in the emergency department and more portering shifts to help improve patient pathways and reduce waiting time and 12 hour trolley breaches, and to give improved access to diagnostics respectively.

Additional actions to help the situation will take place over the coming weeks and will include the following:

- The opening of additional 8 beds in Planned Investigation Unit (PIU) at the PRUH site - 10 beds opened with a further 6 beds planned from 14 February.
- The opening of two modular theatres at Orpington (in addition to the three already opened) to provide a shift of elective day cases from PRUH and enable the establishment of rapid access to surgery.
- Three additional paediatric beds opened and regularly staffed (already started).
- The Urgent Care Centre will be open 24/7 from the 24 January 2014.
- The Clinical Decision Unit (CDU) will be opened in mid-February and this will be fully staffed.
- Enhanced clinical leadership and staffing at PRUH in Medicine and Surgery with support provided by CCG Clinical Chair.
- Intensive Support Team (IST) representative working alongside senior ED staff to implement changes and improve A&E Pathway
- CCG Chief Officer leadership in senior stakeholder meetings to address current issues, especially those identified with discharges.
- New Fractured Neck of Femur (NoF) pathway implemented in late January.

6. Performance Assurance

In order to ensure that all these actions are on track, there is significant effort invested in providing assurance, for example:

- Normal twice weekly (currently daily) multi agency conference calls to review pressures and performance, and to trouble shoot any agency interface issues
- KCH internal PRUH site specific weekly Emergency Care Board meetings, which the CCG officers attend and daily breach meetings.
- Monthly performance meetings between CCG commissioners and KCH to review all key performance targets and recovery plan delivery.

- Monthly (currently two weekly) Urgent Care Working Groups and Network, review acute performance and ensure wider whole system actions to support admission avoidance and discharge processes are in place.
- Monthly Clinical Quality Review Group, which focuses specifically on issues related to patient safety and quality, and includes A&E as a specific standing item.
- Monthly Clinical Summit meeting, this provides the forum for senior leadership (Chief Executive and Medical Director) review and discussion as well as an escalation point. .
- KCH producing a fortnightly update for CCGs, NHSE and Monitor on ED performance at both sites.

7. Summary

There is a great deal of commitment to improve the quality and standard of urgent care services for Bromley patients across the whole health and care economy. There is confidence amongst agencies that the short term plans will be achieved, which will assist in ensuring the fluctuations in performance are reduced and the increased pressures are manageable.

The system wide outlook continues to focus on ensuring that arrangements for the longer term are sustainable in managing pressures in the future.

The way forward for longer term improvement includes implementing all agreed actions and reviewing their impact:

1. Implementing recommendations following the NHSE safety and quality visit, the CQC report and the IST review.
2. Ensuring assessment of the Recovery Plan after Q3 and Q4 and agreeing 14/15 performance trajectories and funding agreements as part of the 14/15 contracts.
3. Robust system management and assurance mechanisms as per the arrangements already in place

Rey Aziz
Angela Bhan
January 2014

HEALTH SCRUTINY SUB-COMMITTEE

Minutes of the meeting held at 4.30 pm on 14 October 2013

Present:

Councillor Pauline Tunnicliffe (Chairman)

Councillors Reg Adams, Ruth Bennett, Roger Charsley, John Getgood, David Jefferys, Mrs Anne Manning, Catherine Rideout and Charles Rideout

Brebner Anderson, Angela Clayton-Turner, Linda Gabriel, Brian James, Leslie Marks and Lynne Powrie

Also Present:

Councillor Robert Evans and Councillor Diane Smith

10 APOLOGIES FOR ABSENCE AND NOTIFICATION OF SUBSTITUTE MEMBERS

Apologies were received from Councillor Getgood and Councillor Fookes acted as his alternate.

11 DECLARATIONS OF INTEREST

Councillor Adams declared an interest as his wife worked for Bromley Community Counselling.

Councillor Diane Smith declared an interest as a member of the Board of Bromley Healthcare.

Brebner Anderson declared an interest as a Governor of Bromley Healthcare.

12 QUESTIONS FROM COUNCILLORS AND MEMBERS OF THE PUBLIC ATTENDING THE MEETING

No questions were received.

13 MINUTES OF THE MEETING OF HEALTH SCRUTINY SUB-COMMITTEE HELD ON 14th February 2013

The minutes of the meeting held on 14th February were agreed subject to some minor typing amendments and adding Councillor Diane Smith to the list of attendees.

RESOLVED that the minutes of the meeting held on 14ht February 2013 were agreed.

14 MATTERS ARISING FROM PREVIOUS MEETINGS

The Chairman had requested that the Terms of Reference for the committee be circulated.

15 Briefing Presentations

A) Public Health England - Priorities and Challenges

Members received a presentation from Dr. Marilena Korkodilos Public Health England (London). The Slides for this presentation are attached at Appendix A.

Members noted there was considerable work being undertaken by both Public Health England and Public Health Bromley and questioned how this would impact on Bromley.

In terms of Diabetes the diabetes audit was ongoing and this informed Bromley of the different levels and groups of patients

Obesity patients were being profiled and to develop more specialised interventions. This was linked to Kings and was an opportunity for Bromley to become a leader in this field.

For Obesity Members requested a breakdown on the numbers of adult's and children and also a detailed breakdown on the costs of prescribing and clinics for smoking cessation.

B) Public Health Locally - Responding to National and Local Priorities

The Committee received a presentation from Dr Nada Lemic, Public Health, London Borough of Bromley.

Members discussed the presentation. For emotional health it was envisaged this would involve Oxleas in terms of preventing mental illness. Dr Lemic was due to meet with the Directors shortly.

For reducing childhood obesity the programme was to educate families. Children would be weighed in Reception and year 6 and where weight was an issue families would be offered to support for weight reduction.

Data would be collated would be shared with schools and joint working would be undertaken to look at ideas to try and reduce childhood obesity.

Members asked about plans for dementia sufferers and their carers. Dr Lemic explained there would be a separate area for Carers support. As the numbers of dementia sufferers was rising work had been undertaken between the NHS and the CCG.

In response to a question Dr Lemic explained that Public Health offered played a support and advisory role to the Public Health Teams. There was a difference between the local and national priorities. In terms of direction Public Health England did not have control over Local Public Health.

C) NHS England - Priorities and Challenges

The Committee received a presentation from Colin Bradbury. Questions for this presentation and the presentation on NHS Bromley were taken together.

Members raised concerns that numbers attending outpatients clinics had declined and this may be that the clinics have moved.

Officers explained that the aim was to provide out patient services locally but in come instances they were provide centrally with Kings being the route for services. Other London hospitals were also used for different specialism. One area of thought was that local GP's also specialise in one area and not all practices would offer every service. However it was noted that this concept would be alien to GP practices and would need careful planning.

Members were aware that in relation to older people discharge did not have a good reputation. However the NHS was now funded to deliver social care and discussions at Health and Well being and officer level would determine how best to accommodate these needs within the budgetary constraints. In addition Bromley needed to work with NHS England to ensure the best use of services.

Members requested the percentage of patients in Bromley suffering with dementia. Officers would distribute this information to members. When considering Proactive Management and Integrated Services for the Elderly (PROmise) the goal was to be able to identify and manage cases in the community. Have a joint liaison with psychiatric services to identify those that are admitted to hospital and to undertake preventative work in the community.

Members requested information on the steps that would be taken if the CCG was found to be under performing. In response they were told that if the CCG was experiencing challenges NHS had a system in place to support it.

Members discussed the confusion around which number the public should use for medical advice, to avoid dialling 999. The status of the 111 service was also queried and officers agreed to provide briefing papers on the current status.

Officers reported that the CCG was developing an urgent care centre. This would be a new contract and would work differently to the current service. In January 2014 some of the current staff at Kings would move across to work in the Urgent care centre.

It was also explained that there was a duty to develop general practice. The CCG had had the ability to commission some services from GP practices.

Bromley health care was sub contracting GP's to provide diabetic care overseen by a senior consultant at Kings. Better control would reduce the instances of renal, heart and eye problems and therefore GP's were being requested to identify patients before they needed hospital care.

Members asked officers how all the new ventures would be communicated to residents, it was explained that it will be publicised but only once the problems at the PRUH had been addressed.

Members also highlighted that some staff at the PRUH did not feel they were being kept up to date with developments. Mr Merriman explained that as they were now employed by Kings they would receive and induction.

D) NHS in Bromley - Priorities and Challenges

Dr Angela Bhan, Accountable officer Bromley CCG gave a presentation to members. Questions for this presentation were taken with questions for the presentation on NHS England and are recorded under the previous agenda item.

E) Improving Quality at the princess Royal University Hospital And the Accident and Emergency Department

The committee received a presentation from Mike Marrinan, Executive Medical Director Kings College Hospital NHS Foundation Trust.

Members welcomed the proposals for development of Bromley services but wanted clarification as to how these developments would be communicated to the public.

In response they were informed that the developments would be publicised once the emergency pathways and the problems at the PRUH had been addressed.

Members also highlighted that come staff at the PRUH did not feel well informed about the changes. They were advised that now they were employed by Kings they would receive an induction.

F) Mortality Rates

This presentation was combined with the presentation on Orpington hospital and Improving Quality at the Princess Royal University Hospital and the accident and Emergency Department.

G) Orpington Hospital Update

This presentation was considered with the presentation on Mortality rates and Improving Quality at the Princess Royal University Hospital and the accident and Emergency Department.

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16 Future Work Programme Items following on from the presentations

If Members had any items which they wished to bring to the Committee these should be directed to the Chairman to forward to officers.

17 LOCAL GOVERNMENT ACT 1972 AS AMENDED BY THE LOCAL GOVERNMENT (ACCESS TO INFORMATION) (VARIATION) ORDER 2006 AND THE FREEDOM OF INFORMATION ACT 2000

RESOLVED that the press and public be excluded during consideration of the items of business referred to below as it is likely in view of the nature of the business to be transacted or the nature of the proceedings that if members of the Press and public were present there would be disclosure to them of exempt information.

The following summaries refer to matters involving exempt information

18 CONTRACT AWARD INTERMEDIATE CARE

The committee considered a report on the contract award for intermediate beds. It agreed the recommendations.

The Meeting ended at 6.56 pm

Chairman

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Report No.
CS14021

London Borough of Bromley

PART ONE - PUBLIC

Decision Maker:	**Health Scrutiny PDS Committee**
Date:	**30th January 2013**
Decision Type:	Non-Urgent Non-Executive Non-Key
Title:	**ProMISE (Proactive Management & Integrated Services for the Elderly) programme**
Contact Officer:	Paul White, Associate Director of Development & ProMISE Programme Director Bromley Clinical Commissioning Group Tel: 01689 880567 E-mail: paul.white@bromleyccg.nhs.uk
Chief Officer:	Angela Bhan, Bromley Clinical Commissioning Group
Ward:	Borough-wide

1. Reason for report

To inform the Committee of progress with Bromley Clinical Commissioning Group's ProMISE programme. The programme was presented to the November 2013 meeting of the Health & Wellbeing Board, who gave its support for the projects within the programme.

2. RECOMMENDATION(S)

The Members of the Committee are asked to note progress with the ProMISE Programme.

Corporate Policy

1. Policy Status: Not applicable
2. BBB Priority: The programme aims to address many of the challenges and the identified priorities described within the Health & Wellbeing Strategy: diabetes, hypertension, anxiety and depression, dementia and support for carers.

Financial

1. Cost of proposal: £7.5m over three years (non-recurrent)
2. Ongoing costs: N/A
3. Budget head/performance centre:
4. Total current budget for this head: £
5. Source of funding: NHS resources held under a Section 256 agreement

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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: N/A
2. Call-in: N/A

Customer Impact

1. Estimated number of users/beneficiaries (current and projected): The programme is Bromley-wide with a primary focus on older people (there are approximately 60,000 people aged 65 and over living in Bromley) and people with complex health needs. In the longer term all Bromley residents have the potential to benefit from a programme aimed at delivering a more proactive, coordinated and integrated approach to the delivery of health and social care in Bromley.

Ward Councillor Views

1. Have Ward Councillors been asked for comments? No, reports on the ProMISE programme are given regularly to the Health & Wellbeing Board, however.
2. Summary of Ward Councillors comments:

3. COMMENTARY

3.1 Bromley Clinical Commissioning Group has identified long-term conditions and care for older people as one of its six strategic programmes. Focusing on systemic change of care delivery, service integration and a proactive and holistic approach to the care of patients; this programme was branded as ProMISE.

3.2 Central to ProMISE is a determination to systematically change the way in which health and social care is delivered; shifting the requirement of unplanned care delivered in an acute (secondary care) setting, after reacting to an unpredicted health crisis, to a more proactive, coordinated and integrated approach.

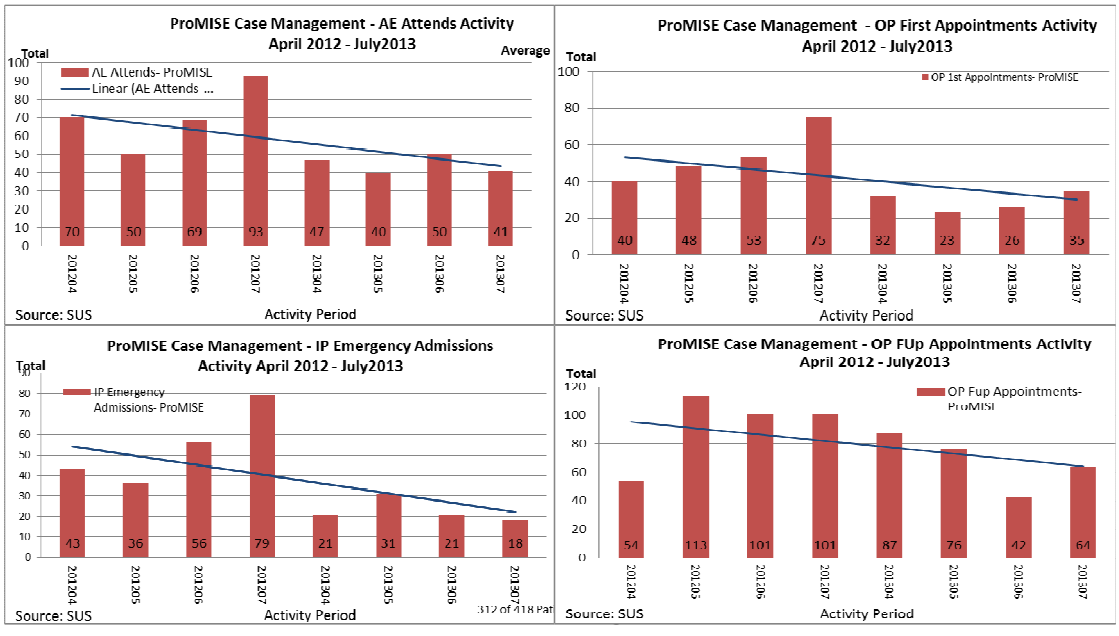
3.3 Success is dependent upon our ability to prevent complex and often older patients from worsening ill-health and to maintain and promote independent high standards of living. Risk stratification is now capable of identifying those patients at higher risk of their chronic and complex health issues escalating to a point of needing secondary care intervention. This in turn enables us to respond proactively, offering individualised case management in a community setting with a range of additional support services aimed at maintaining and improving their current health and quality of life and preventing the anticipated crisis.

3.4 We are now seeing tangible benefits of the many component enabling projects. We are building a system that anticipates, identifies and responds to individual needs and encourages and enables partnership working among health and social care professionals; to provide coordinated and person centred care that can help keep local people out of hospital and residential/nursing homes where appropriate. There is growing evidence that a significant reduction to emergency bed days and/or early admission to residential or nursing homes is achievable with the use of case-finding and proactive intervention for patients before their "intensive year" of need.

3.5 There is an expectation, moreover, that earlier intervention and the active promotion and support for self-management will reduce the overall burden on health and social care services in the medium to longer term.

3.6 The following summarises the individual projects that comprise the programme and where demonstrable the measurable impact that each is having:

- Case Management – twenty-one of forty-six GP practices have been risk stratifying and referring suitable patients via the Bromley Healthcare Single Point of Entry (SPE) to dedicated community matrons within the ProMISE team. The matrons undertake bespoke home-based complex case assessments; coordinating any health and social care and voluntary sector input, both for the patient and any unpaid carer. They follow patients up after several weeks to sign off a care plan, which includes a self-care component. Analysis of 268 of the 418 patients supported in this way suggests this is having a significant impact on their demand for hospital services:



Year on year financial comparison for ProMISE patient cohort (268 patients)

Total Spend 6 Months prior to ProMISE	£1,455,513
Total Spend 6 Months post ProMISE	£747,813
Avoided costs (6 month post ProMISE)	**-£707,700**
Avoided costs excluding elective admissions (6 month post ProMISE)	**-£546,804**
Avoided costs unscheduled care only (6 month post ProMISE)	**-£487,532**

This activity comparison relates to 18 GP practices covering 52% of the Bromley registered population and is limited to 268 of the 418 patients supported on the basis of the availability of six months of post-ProMISE intervention hospital data.

If this impact were extrapolated to encompass all GP practices in Bromley, the full year effect in terms of avoided secondary care activity and spend could be:

If all practices were on the Programme with 1.3% (average of practices analysed above) of over 65s actively managed:

Total No. Patients		**705**
Potential cost avoided	All Activity	**-£1,861,673**
	Excluding Elective	**-£1,438,421**
	Unscheduled Care Only	**-£1,282,500**

Analysis of the outcomes, suggests that patients identified through case management will typically require low level social care advice and support if any, with many of the patients identified as requiring such support already known to the social care team. Of the 418 patients seen, for example, only fifteen required any form of social care intervention, with all the patients already known to social care and typically receiving low level support, such as drop-off to day-care facilities. Only three of the patients required reassessment following the input of the community matron and continued to receive low level support, thereafter.

- Integrated Care – Bromley Healthcare is responding to our commissioning strategy and has reconfigured its services to work in six co-located locality teams. Each team will work closely with a local group of GP practices covering registered populations of approximately 50,000 residents. Dedicated and additional community matrons will be undertaking home-based complex case assessments and care planning and multi-disciplinary teams will work closely with GP practices, named mental health and social care staff and newly commissioned enhanced end of life care services to manage effectively patients with complex needs and/or long-term conditions.

  In one of the six localities, an integrated care team pilot already underway has introduced a dedicated community psychiatric nurse to work full-time with Bromley Healthcare; working with the community matrons and multi-disciplinary teams and bringing a primary mental health presence to the locality. Similarly, we are working with local authority colleagues to bring a similarly dedicated and co-located social care manager/assistant to the team. The expectation being that this will enable closer, better coordinated and therefore more effective working for the benefit of Bromley residents. We will also take the opportunity of this extended pilot to very carefully monitor the impact of this proactive and integrated way of working on primary, community, mental health and social care services.

  Analysis to date suggests that there is unmet need for therapies among the patients referred for case management and it is likely that further investment in occupational therapists and physiotherapists will be required to support the more proactive management of patients in the

community and their own homes, whilst there may need to be further but non-recurrent investment in district nurses as we effect the transformation from a community caseload largely derived from reactive provision to one largely derived from proactive care.

Following changes to rules relating to the sharing of patient identifiable data at local level, the risk stratification tool that had been supporting case management is no longer viable. GP practices have been relying instead on clinical judgement to identify patients suitable for assessment and care planning but this has reduced throughput. The ProMISE team is now working with EMIS to develop and implement a new predictive risk tool that relies solely upon GP practice data, thereby overcoming the restrictive changes to information sharing. Investment in training and development and user licences over the next three years will need to be made to achieve this. The plan is to have an interim solution in place by April 2014 and to commence roll-out of the new tool from July 2014.

Significantly, Bromley Healthcare are adopting EMIS as their patient record system, whilst 43 of 46 GP practices in Bromley also use the system. This offers the further opportunity of developing EMIS as the basis for an integrated shared care record. The significance of this is not to be underestimated. It could place Bromley at the forefront, by realising an information system that supports truly integrated working; greatly enhancing our ability to offer holistic and coordinated care to patients with complex needs and/or long-term conditions.

- Falls and Fracture prevention – Bromley Healthcare is now accepting referrals from GP practices into their newly commissioned service and will shortly be accepting referrals from other health and social care professionals; approximately thirty GP referrals were made to the new service in December. The ProMISE programme has also incentivised GP practices to set up falls registers, identifying patients with a history of falls or perceived higher risk of falling, i.e. due to other health conditions perceived frailty, social isolation and polypharmacy issues. New falls clinics based in multiple community settings staffed by a Falls Coordinator, nurse, consultant, physiotherapist and occupational therapist will be seeing up 30 patients a week. Whilst a new Fracture Liaison Nurse, working with a counterpart being recruited by King's Healthcare NHS Foundation Trust, will be seeking patients in A&E and fracture clinics with fragility fractures (which are indicative of osteoporosis) for DEXA scanning and osteoporosis treatment, as well as seeking non-fracture fallers for referral to the community falls clinics. Finally, this greatly enhanced package will be complemented by weekly exercise and balance classes at multiple community locations across Bromley. This service should prevent falls and fractures arising from falls, as well aiding the recovery from falls.

- Diabetes – the ProMISE programme is supporting the development of the primary care workforce, through a comprehensive training programme now underway, and the redesign of diabetes pathways incorporating the provision of an advanced primary care service. The aim is to ensure that every person with diabetes in Bromley receives personalised care from trained primary care healthcare professionals with faster access to specialist care, advice and support as and when required.

  The investment will:
  help ensure that NICE guidance outcomes are met by all GP practices (currently 50% compliance); that the Diabetes UK 15 care essentials are met through basic level training for GP practices (currently variable);
  mean that specialist resources are accessed more appropriately and effectively (currently inappropriate use of specialist services for routine care);
  support fast access to specialist advice (neither timely nor coordinated currently);
  support the accredited training of GPs and nurses to provide insulin management (currently little or no education and training otherwise available with variable standards)

help create a single, dedicated specialist team (consultant and diabetes nurse) working across secondary and community care is in place (currently limited availability and capacity and poor coordination across the two sectors)

The benefits for patients will be:
local access to a full range of services;
personalised care plans in primary care, shared with secondary care;
responsive services with improved access to specialist care when required
improved clinical outcomes through a proactive and responsive truly integrated and trained workforce to consistent standards of care.

Secondary benefits:
overall reduction in diabetes related morbidity and mortality and associated complications such complex neuropathy and renal failure

This development recently received recognition by way of an innovation reward for 'pushing the boundaries of diabetes care in primary care' from the South London Membership Council

- End of Life Care – the St Christopher's Group is now providing an enhanced end of life care service. They are providing a new 24 hour coordinated care centre for patients and carers – case-finding coordinating and directing care for a further 800 patients per annum; ensuring that the patients are on the Continuing My Care register (there has already been a marked improvement that has seen Bromley move into the top five best performing CCGs across London); ensuring that care plans are in place with the appropriate partners; attending relevant multi-disciplinary team and GP practice meetings; working closely with discharge co-ordination teams at the Princess Royal University Hospital; and coordinating the attendance of end of life care personnel at GP practice Gold Standard Framework or hospital multi-disciplinary team meetings. The aim is for admissions in the final year of life and deaths in hospital to be avoided by supporting patients to enable them to remain and die at home, should they wish. ProMISE monies will be ring-fenced in 2013/14 to fund any additional community equipment costs arising and arrangements have been established with our colleagues in the local authority to both enable access and monitor demand.

- Self-care and monitoring – FLO is a low cost and very simple healthcare system provided via the patient's own mobile phone or landline. It is primarily an automated SMS (text) messaging based system that clinicians use to send reminders, health tips and advice to patients; and collect, monitor and track their health readings taken by the patient using self-monitoring equipment e.g. Blood pressure machines. Patients can text back their readings to FLO. Text messages to FLO for patients are free even if the patient has no credit.

  Thirty-five GP practices have enrolled and patients are being signed up to the self-monitoring scheme (80 patients signed up as at the end of December). The priority condition chosen for monitoring is hypertension; a recognised priority health need in Bromley. Other protocols covering asthma, COPD and smoking cessation are also being adopted this year.

  The evidence, resulting from evaluations of FLO around the country, shows clear health benefits for the patients and productivity benefits for clinicians. We have developed pre- and post- FLO patient questionnaires to measure whether patients feels better equipped and more confident to self-manage and are less reliant on primary care consultations than before. We have also developed a GP practice questionnaire to gauge their confidence and satisfaction with the system. Finally, subject to the limitations upon access to patient identifiable information, we are attempting to set up monitoring of actual primary care consultations, A&E attendances and admissions for individual patients pre- and post-FLO; to measure the impact of close and frequent monitoring and timely responses to changes in patients' vital signs.

Following a recent options appraisal, plans for investment in self-care are being further developed in three distinct areas:

information and advice;
self-management; and
training of healthcare professionals in motivational coaching

Self-care is anticipated to be a commissioning priority going forward as it is felt to have the potential to impact greatly upon future demand for health and social care. Any further investment will need to be targeted in those areas that have the potential to achieve the greatest impact and any case for investment will be underpinned by demonstrable local need, supporting evidence of success and value for money.

- Patient Liaison Officer (PLO)scheme – the ProMISE programme is now supporting this highly innovative primary care workforce development initiative that has attracted national recognition. A second series of workshops in early 2014, will result in almost 100 GP practice receptionist and administrators having developed a new set of skills. The role envisaged is not dissimilar to that of a hospital Patient Advice & Liaison Service (PALS) but the PLO aims to support vulnerable patients and carers in anticipation of their needs rather than respond to a problem; the aims being to prevent problems, avoidable admissions and poor communication. The PLO will support proactive integrated care and more effective communication and coordination between patients (and carers) and integrated care teams, whilst reducing the administrative burden of care on GPs which in turn affords them more time to focus on meeting the needs of their most complex and elderly patients.

  The ProMISE programme is supporting two GP practice initiatives to enable PLOs to apply the skills learned and to begin to deliver their anticipated role - trained PLOs are creating falls registers and carer registers in their practices. The PLOs are identifying patients who have a history of or are at perceived risk of falling, linking to the new Falls service described above. They are also identifying and considering carers as vital members of an integrated care team; as important stakeholders in the design and delivery of services; and as patients with their own health and support needs.

- Urinary Tract Infection (UTI) training – there are many admissions of people aged 65 and over with UTIs which can often be prevented if identified and treated earlier. We have set up free training sessions for non-clinical nursing and care home staff, domiciliary care workers, day centre staff, the reablement team and informal carers. Each session provides information about the causes of a urine infection, prevention, symptoms and common treatments. Carers also learn how to carry out a urine 'dipstick test', which can help exclude or confirm the presence of a urine infection and enable earlier treatment as appropriate.

  Community Matrons are now delivering the training at a range of venues across Bromley and after a slow start the numbers have now increased significantly, with considerable support from colleagues within the London Borough of Bromley to market the training. There have been 261 applications for training with seventeen training sessions held. Nine UTIs have been identified to date, which if left untreated would most likely have led to hospital admission. The feedback from course attendees has been excellent and we intend to continue to market and run free training sessions for the remainder of this year and throughout 2014/15.

4. FINANCIAL IMPLICATIONS

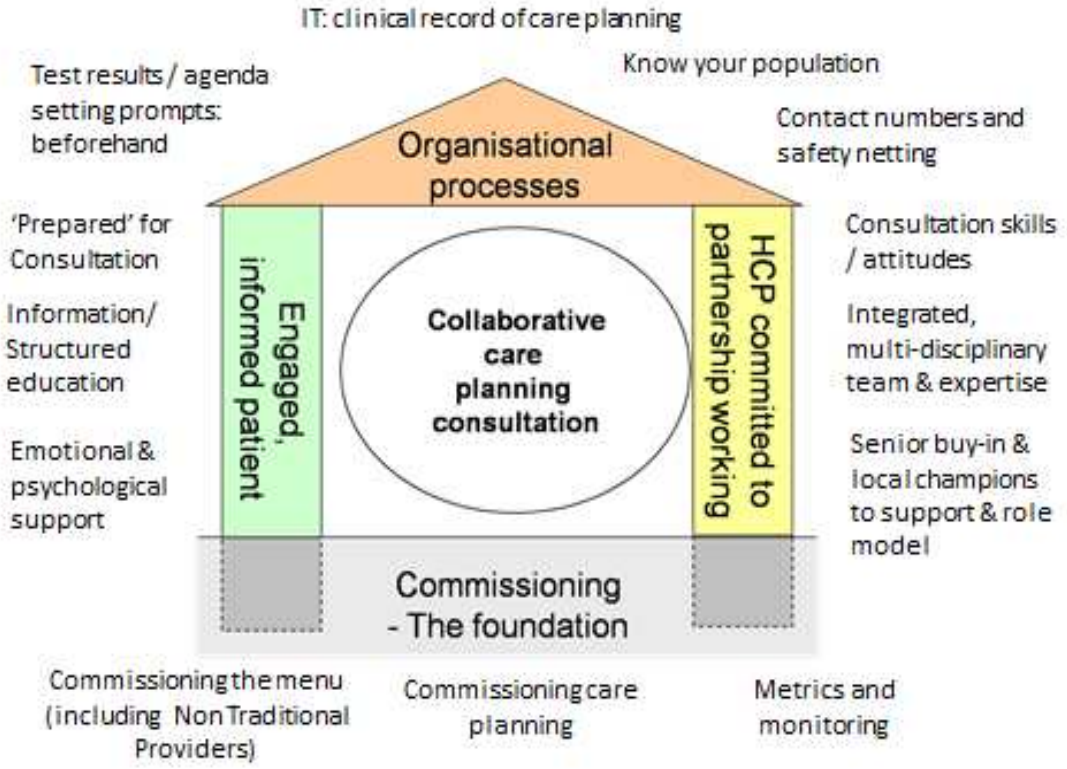
4.1 The funding for this programme is derived from health monies now held by the London Borough of Bromley, having been transferred by way of a Section 256 agreement. The Executive

approved the release of ProMISE funds for the activities for 2013-14 and approved planned expenditure for 2014/15 and 2015/16 at its meeting held on 15 January 2014.

5. POLICY IMPLICATIONS

5.1 With the advent of the Better Care Fund, colleagues across the Clinical Commissioning Group and London Borough of Bromley are now collaborating to use the Fund not purely as a vehicle for funding the back-fill of existing social care budgets, but as the focus for working jointly across health, social care and the third sector to reduce long-term dependency, promote independence and drive overall improvements in health and wellbeing; moving from a reactive, bed-based model of provision to a proactive community and home-based model with a strong emphasis on self-care for the individual and their "community" and with providers working collaboratively to deliver person centred and coordinated care in partnership with local people and their carers.

5.2 We have begun to describe this concept as the "House of Care"



5.3 In building our Bromley 'House of Care', non-recurrent additional investment will be made in skills, capacity, behavioural and cultural change, equipment and infrastructure across health and social care to secure person-centred, safe, needs driven, high quality and integrated alternatives to secondary and nursing home care services and enhanced rehabilitation / reablement services which will reduce hospital readmissions and admissions to residential and nursing home care.

5.4 We will also invest in empowering local people through effective care navigation and a menu of self-management options ranging from advice and information, education, support for carers, access to telehealth and health coaching to maximise their independence and wellbeing; and we will help identify and combat social isolation, as a major influence on overall health and wellbeing, with initiatives such as the award winning Bromley Leg Club and through closer and more effective collaborative working with communities through our partners across the third sector.

5.5 We are enhancing our already effective risk stratification and care planning tools in health to work effectively across social care also. We are aiming to develop a single care planning tool and interoperability between all systems that will provide both real time information and managerial analytics, starting by ensuring that GP and Social Care systems across Bromley are integrated around the NHS number.

5.6 In summary, the BCF will enable us to start to release health funding to establish accessible and integrated services that proactively work with current and future high risk individuals, irrespective of eligibility criteria.

5.7 This more coherent, joined up and proactive approach in both commissioning and provision will improve our efficiency and the management of demand within both the health and care systems and reduce the reliance upon high cost emergency care beds. In turn, this will enable us to work sustainably within our current and future organisational resources, in the face of an increasingly ageing population, whilst simultaneously expanding the range of services and improving the quality of outcomes for individuals. and reduce the reliance upon high cost emergency care beds. In turn, this will enable us to work sustainably within our current and future organisational resources, in the face of an increasingly ageing population, whilst simultaneously expanding the range of services and improving the quality of outcomes for individuals.

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

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