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To: Members of the
HEALTH AND WELLBEING BOARD

Councillor Peter Fortune (Chairman)
Councillor David Jefferys (Vice-Chairman) and Councillor Diane Smith (Vice-Chairman)
Councillors Reg Adams, Ruth Bennett, Judi Ellis, Peter Fookes, Ellie Harmer, William Huntington-Thresher and Charles Rideout

London Borough of Bromley Officers:

Dr Nada Lemic	Director of Public Health
Terry Parkin	Executive Director: Education, Care & Health Services (Statutory DASS and DCS)

Clinical Commissioning Group:

Dr Angela Bhan	Chief Officer - Consultant in Public Health
Dr Andrew Parson	Clinical Chairman

Bromley Voluntary Sector:

Linda Gabriel	Healthwatch
Sue Southon	Chairman, Community Links Bromley

A meeting of the Health and Wellbeing Board will be held at Bromley Civic Centre on **THURSDAY 28 NOVEMBER 2013 AT 1.30 PM**

MARK BOWEN
Director of Corporate Services

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

AGENDA

1 APOLOGIES FOR ABSENCE

2 MINUTES OF LAST MEETING AND MATTERS ARISING (Pages 1 - 8)

3 QUESTIONS BY 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 22nd November 2013.

4 WINTERBOURNE VIEW UPDATED (Pages 9 - 12)

5 A&E PERFORMANCE (Q3) - EXPECTED MULTI AGENCY

This item to follow

6 JOINT STRATEGIC NEEDS ASSESSMENT 2014 & HEALTH AND WELLBEING STRATEGY REFRESH (Pages 13 - 18)

7 INTEGRATION TRANSFORMATION FUND (TTF) 2015/16 (Pages 19 - 32)

8 BOARD MEMBER DEVELOPMENT & ENGAGEMENT PROGRAMME

This item will be now considered at the Health and Wellbeing Board meeting in January 2014.

9 PROMISE PROGRAMME (Pages 33 - 42)

10 QUESTIONS ON THE HEALTH AND WELLBEING BOARD INFORMATION BRIEFING

The briefing comprises:

- Public Health Annual Report

This item to follow

11 FUTURE MEETINGS AND AGENDA ITEMS

12 ANY OTHER BUSINESS

13 DATE OF NEXT MEETING

HEALTH AND WELLBEING BOARD

Minutes of the meeting held at 1.30 pm on 26 September 2013

Present:

Councillor Peter Fortune (Chairman)
Councillor David Jefferys (Vice-Chairman) and Councillor Diane Smith (Vice-Chairman)
Councillors Reg Adams, Ruth Bennett, Judi Ellis, Robert Evans, Ellie Harmer and William Huntington-Thresher

Dr Nada Lemic (Director of Public Health) and Terry Parkin (Executive Director: Education, Care & Health Services (Statutory DASS and DCS))
Dr Angela Bhan (Chief Officer - Consultant in Public Health) and Dr Andrew Parson (Clinical Chairman)
Leslie Marks (Bromley Council on Ageing) and Sue Southon (Chairman, Community Links Bromley)

1 Apologies for Absence

Apologies for absence were received from Councillor Peter Fookes, Councillor Charles Rideout and Linda Gabriel, Chairman of Bromley Healthwatch (Leslie Marks attended as her alternate.)

2 Questions by Councillors and Members of the Public Attending the Meeting

Three written questions were received from Mrs Sue Sulis. These are attached at appendix A.

3 Minutes of Last Meeting on 29th July 2013 and Matters Arising

The Chairman provided a general update on progress since the last meeting. He explained there had been a lot of activity. Extended workshops involving Bromley, the Local Government Association (LGA), the Greater London Authority (GLA) and Kings Health Trust (Kings). As a result the agenda for progress was starting to develop and the Chairman was working with colleagues to “drive” it forward.

He was also pleased to report a recent email stating that Kings would be taking responsibility for the hydrotherapy pool located at Orpington Hospital.

An updated version of the minutes was circulated prior to the meeting. Copies were also circulated at the meeting.

Matters Arising

Minute 5

Case Management

In response to a question regarding if the "teams" mentioned in the minutes would be accommodated on the Orpington Hospital site the Board were informed that no decision had been made.

The site would definitely house the Health and Wellbeing Centre which would then include outpatients. It would be for Kings to decide on the future of the site but current information indicated the site would remain open for the next 3 years and then reviewed.

Integrated Care

Dr Parson reported that a GP event, an academic half day, had taken place. During the event various issues had been considered including the "Year of Care", mechanisms for promoting self care and a presentation from Dr Sue Roberts, National Clinical Director for Diabetes.

One board member raised an issue in relation to integrated care of diabetes. For dementia sufferers carers would need to be trained.

RESOLVED that the minutes of the meeting held on 29th July 2013 be agreed.

4 Work Programme and Matters Arising

The Board considered its work programme.

The Chairman asked for an update on when the Board might have further information on the proposal for how paediatric diabetes could be addressed jointly between the Local Authority and Bromley CCG, focusing on prevention.

Dr Bhan reported that at present the focus was on adult diabetes but that paediatric diabetes was part of the CCG's Children and Young Peoples Programme to be considered in due course.

In response to a question, officers were able to confirm that the Children's Charter had been previously presented to the Board. It was also contained in the Joint Strategic Needs Assessment (JSNA).

RESOLVED that the work programme and matters arising report is noted.

5 Development of Integrated Commissioning in Bromley

The Board was informed that the report had been a collaboration between the

report author, Dr. Bhan and Clive Uren.

In June 2013 the Bromley CCG Chief Officer and London Borough of Bromley Executive Director of Education, Care & Health commissioned a piece of work to assess the benefits of greater integration of commissioning arrangements across the two organisations. This work explored, with existing lead commissioners, clinicians and other key leads what LBB and CCG currently commissioned and how the commissioning functions were organised. In addition, the drivers and objectives for integration were assessed and a number of other health and social care economies visited in order to consider how they had approached integration and what they considered to be the benefits, risks and opportunities.

The Board considered a briefing paper that summarised the conclusions of this work and outlined a set of proposals for integrated commissioning in Bromley. Officers explained that Mental Health Services would be used as a "test" service as it was a relatively small budget. The Board was informed that the Chancellor had announced a "pooled" budget of £3.8bn to drive forward integrated commissioning. The Health and Wellbeing Board would be able to draw on this budget.

Integration between Health Authorities and Local Authorities had been the aim of successive governments. In order to further the integration in Bromley a number of local Health and Social Care economies had been approached to discover how they dealt with integrated commissioning in practice. There were varying levels of integration with some boroughs having all or some services integrated to others that had a joint CCG Chief Officer/Director of Adult Social Care, accountable for both management and commissioning of all CCG and LA Services. In all areas both GPs and Councillors were happy, and signed up to the arrangements, agreeing the mutual benefits of the economy of scale and the opportunities for efficiency, saving and community based improvements. There were still some issues to overcome such as different cultures and approaches generally.

Officers then outlined the proposed approach for Bromley; the Bromley CCG Chief Officer and London Borough of Bromley Executive Director of Education, Care & Health believed that mental health should be the first area of focus as integration was not a new agenda for mental health services. Many steps had been taken by both organisations to move in this direction over the past few years.

The Board expressed concerns that the report did not fully clarify the role of the HWB nor outline the efficiencies. It was agreed that further reports would be submitted to the board outlining the model for delivering mental health services and giving detailed outcomes.

The Director explained that there were still a number of other issues, not just financial, such as clinical governance. Integration would force a solution to some of the issues that had not yet been concluded. The Board also requested a structure chart for the integrated services.

Councillor Ellis felt that the integrated service caused concern for some in relation to grants. Integration would mean they would no longer receive grants from both

the Local Authority and Health Authority therefore partners needed to be reassured that this would not be detrimental to patients. With mental health there were joint contracts between the voluntary sector and the CCG.

6 2014 Joint Strategic Needs Assessment Planning Milestones (Oral Update)

An update on the JSNA would be given at each Health and Wellbeing meeting. However it was agreed that it would be in the form of a written report.

Nada Lemic provided a verbal update. She explained that a new JSNA was being developed; a steering group had been organised and its first meeting was scheduled for 14th October. It would be looking at the structure of the JSNA. The areas in the new document would include:

- Looking at the gaps – in particular with regard to public health outcomes.
- Considering community assets which would better inform with regard to commissioning.
- Whether more detail was needed in certain areas.

Members considered the update.

They raised concerns that creating joint integrated services would mean being answerable to a larger number of people and felt it was important to produce a diagram to illustrate the scrutiny pathway.

It was also noted that a number of people who currently received grants from more than one sector such as health and the Local Authority and for them integrated services would mean a change of culture. Therefore reassurance would be needed for both the recipients and partnership agencies. Members also felt it was important that when health and social services merged the social care service should not be lost and that care management was not overtaken.

In response they were informed that there was evidence in other authorities of joint contracts in mental health and in social care and the integrity of both services had been preserved.

Officers would provide a more detailed report for the Board in November.

Dr Lemic explained that the Board would also need to consider how best to engage and communicate with residents. The executive summary of the JSNA had been written with the public in mind. The Board would also need a strategy to identify the priorities it wished to focus on.

7 S.256 Funding

Report no. HWB131003

The Board was presented with a report containing a Section 256 for Bromley care and health service which had been produced in order to draw down the Department of Health grant for 2013/14 which stood at £4.26m. An additional paper was distributed at the meeting and the Board asked that, in future, all papers be circulated in advance of the meetings.

Local Authority and Clinical Commissioning Groups proposed to use the funding to deliver against 6 'schemes' which would help to maintain and sustain key community based services important to both organisations that were otherwise struggling to be kept operational due to the significant cuts. Social care budgets since 2010 had been cut by around £2.7bn – or 20 %. A further 10 % cut was announced to local government spending which would also impact upon social care.

To draw down the funding the Section 256 needed to be signed and agreed by both the Local Authority and the Clinical Commissioning Group. Finally it had to be approved at the Local Health and Wellbeing Board before being formally submitted to the London branch of NHS England.

Officers explained that the funding would be used to reduce pressures in services such as dementia and was crucial in order to continue services e.g. the re-ablement service. Officers were still awaiting legislation in relation to Learning Difficulties and how it would be managed; this could be incorporated once known.

The Board requested more detailed information on the position with regard to the hospital discharge programme which had been delivered by Bromley Link. Officers agreed to provide this outside of the meeting.

The funding would be for the current financial year and was built into the budgets on the assumption it would be agreed.

RESOLVED that the draft section 256 is endorsed and it is noted that Chief Officers at both the CCG and the LA would be responsible for securing funding through the NHS England Board on behalf of the Health and Wellbeing Board.

8 NOMINATION FOR THE NHS INNOVATION CHALLENGE PRIZE FOR DEMENTIA (for information)

This item was for information only. In future such items would form part of an information briefing in line with other committees.

9 Date of Next Meeting

The next meeting of the Board would be on Thursday 28th November at 1.30pm.

10 Appendix A

A

Questions from Susan Sulis, Secretary, Community Care Protection Group

1. PROVISION OF 'SAFE STAFFING LEVELS" FOR THE PRINCESS ROYAL UNIVERSITY TRUST & OTHER SOUTH LONDON HEALTHCARE TRUST HOSPITALS.

The HOC Health Select Committee and the 'Safer Staffing Alliance' have called for daily ward sta to be published, and, to ensure patient safety by having "adequate levels of both clinically and n qualified staff in all circumstances".

(a) What are the ratios of nurses to patients at the PRUH?

Response from Kings/PRUH:

"A review of nursing is currently being undertaken on the PRUH site. The ratios currently a standard level across the Trust site and for SLHT as a whole staffing levels are within the param NHS National Quality Board. More information should be available when the review is complete. "

2. SHORTAGE OF A&E PERMANENT STAFF, INCLUDING CONSULTANTS AT THE PRUH.

The HOC HSC expressed concerns that A&E's are struggling to cope with attendances and admissions.

(a) What are the current percentages of permanently employed consultants; junior doctors; nurses in the PRUH's A&E Department?

Response from Kings/PRUH:

"Please note these are the percentages of permanently employed staff in the ED department These are increasing on a daily basis as we continue to recruit to these posts.

a. Nurses: 87.5%

b. Consultants 100% (although there are currently vacancies, shifts are being covered by curre

c. Junior Doctors – 90% (1 locum) "

(b) What are the plans for dealing with Winter Pressures, and where are they published?

Combined response from Kings & Bromley CCG

"Kings/PRUH have done a winter surge plan which takes into account their capacity and ho manage if there is increased pressure. They have also bid for extra winter money for projects at t Royal University Hospital which directly relate to reducing pressure on A&E and improving disc well as this, Bexley, Bromley and Greenwich (BBG) have a combined plan to help manage the beds during winter. The cross-borough urgent care network will be holding twice weekly telecon monitor pressures and manage demand during the winter period.

The BBG plan has just been submitted to NHS England for agreement and a King's appro published on the King's Trust website in the next couple of months."

BROMLEY PATIENTS AT RISK BECAUSE OF THE OVERSTRETCHED LONDON AM SERVICE.

At the inquests of 2 Bromley people who died, where an ambulance was summoned, but neve The South London Coroner has commented on the risk to patients.

(a) Is it correct that up to 800 posts may be cut, due to under-funding?

Response from LAS:

An additional 120 posts have been funded in 2013/14 in combination with a Modernisation p which will result in improved performance and resilience across London as a whole. In addit response cars and ambulances for the most critically ill or injured which has ensured an abov response time in London, enhanced telephone triage and signposting is taking place.

b) What action can Bromley take to save lives?

Response from LAS:

This year Bromley has experienced some of the best Category A performance in London (77.9% which is above the National target level of 75%.

http://www.londonambulance.nhs.uk/news/news_releases_and_statements/ambulance_staff_num

The website above has a link to the Ambulance service's overall plans to improve patient care, which include ca residents. Ensuring that the ambulance services are used wisely, encouraging people to use of alternatives such a centres, walk in centres, GP clinics and the 111 service, plus supporting a strong team of community first responders public locations are all ways that performance can be supported and lives saved.

The Meeting ended at 2.54 pm

Chairman

London Borough of Bromley

PART ONE - PUBLIC

HEALTH AND WELLBEING BOARD

Date: **Thursday 28 November 2013**

Report Title: **WINTERBOURNE VIEW UPDATE**

Report Author: Peter Davis, Joint Team Manager, Education, Care & Health Services
London Borough Bromley
Tel:020 8461 7117 E-mail: peter.davis@bromley.gov.uk

1. SUMMARY

1.1. To provide an update on local actions in response to the Serious Case Review undertaken by South Gloucestershire in relation to Winterbourne View Hospital (Castlebeck).

1.2. Outlined below are the key points:

- All patients admitted have been reviewed and are subject to CPA;
- All qualified Care Managers trained in HoNOS-LD which has been implemented;
- Clinical Teams in the CLDT restructured by Oxleas Foundation Trust to strengthen clinical work with people with LDs with mental health problems;
- Commissioners reviewing arrangements for children and young people;
- Multi-agency monitoring of London Autistic Centre, Glencare;
- ASBU operates RSL panel supporting admissions prevention.

2. REASON FOR REPORT GOING TO HEALTH & WELLBEING BOARD

2.1. The Board is asked to note this report.

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

3.1. No specific action required by the Board. The Council and CCG's local actions are detailed below.

4. COMMENTARY

4.1. There are currently seven Bromley residents accommodated within Hospital settings. Of these, all have been admitted under Section 3 of the Mental Health Act. This is in stark contrast to the situation at Winterbourne House in which a significant minority of patients were not detained under the provisions of the Mental Health Act 1983.

4.2. Admission under section ensures a statutory framework for review with a minimum frequency of 12 monthly reviews. All of the patients concerned have named allocated care managers and named local clinicians, and have received annual Care Management reviews in addition to their Care Programme Approach Reviews. Copies of the reviews have been supplied to CCG commissioners who have reported satisfaction with the quality of the reviews.

4.3. In recognition of the need to monitor outcomes for people with LDs in ATUs, all qualified care managers in the CLDT have been trained in the use of the Health of the Nation Outcome Scales (HoNOS-LD) to evaluate clinical outcomes across a range of scales. The tool can not only measure improvement following treatment but also identify areas of deterioration which can be investigated further as they may be indicators of safeguarding concerns.

4.4. There is a joint group comprised of CCG & LBB Commissioners with the CLDT Joint Team Manager looking at the requirement of the winterbourne view programme and to ensure we deliver to targets.

4.5. LBB and CCG Commissioners are working jointly to ensure there is adequate planning for service users in ATUs who wish to return to borough following discharge, whilst recognising that some people in out of borough ATUs are already settled in the locality where they have been admitted.

4.6. Accountabilities to local, regional and national bodies are clear in both organisations. Reports have been presented to the LBB Safeguarding Board. The CCG Programme Groups for Adults & Children have governance oversight from a CCG perspective with LBB oversight from the Senior Management Team & elected Members.

4.7. The local CLDT was restructured in October 2012 with a newly developed multi-professional functional team, including nurse prescribers, specialising in supporting people with LDs who have mental health problems. The team works to support people in the community, prevent admissions, undertake CPA reviews and support decision making concerning discharge at Atlas House.

4.8. With regard to children and young people, LBB is an SEN Pathfinder and commissioners are reviewing all arrangements regarding services to Children with the CCG. This includes both identification of need, business processes and financial management.

4.9. Advocacy services local to the person in the ATU are engaged to ensure that patient views are heard.

4.10. The opening of a private ATU at the London Autistic Centre by Glencare has resulted in safeguarding alerts resulting in close scrutiny by LBB, the CCG, NHS London and NHS England. Neither LBB nor Bromley CCG have any patients placed within the service, nor have any placements ever been made there. The primary provision for local patients remains Atlas House run by Oxleas Foundation Trust.

4.11. The Anti-Social Behaviour Unit operates a multi-agency panel including registered social landlords, adult social care and the police to monitor vulnerable adults including those with LDs and mental health problems to monitor risks associated with anti social behaviour. CLDT representation on the panel ensures timely information sharing contributing to admissions prevention.

Non-Applicable Sections:	**FINANCIAL IMPLICATIONS** **LEGAL IMPLICATIONS**
Background Documents: (Access via Contact Officer)	None.

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London Borough of Bromley

PART ONE - PUBLIC

HEALTH AND WELLBEING BOARD

Date:	**Thursday 28th November 2013**
Report Title:	**Progress on the 2013/14 JSNA Update & Annual Refresh of the 2012 – 15 Health & Wellbeing Strategy**
Report Author:	Agnes Marossy, Public Health Consultant, ECHS Tel: 020 8461 7531 E-mail: agnes.marossy@bromley.gov.uk Angela Buchanan, Planning & Development Manager, ECHS Tel: 020 8313 4199 E-mail: angela.buchanan@bromley.gov.uk
Chief Officer:	Nada Lemic, Director of Public Health Terry Parkin, Executive Director, ECHS

1. SUMMARY

1.1 **A Joint Strategic Needs Assessment** (JSNA) has been a statutory requirement of local authorities and NHS primary care trusts since 1 April 2008.[1] Original guidance set out an expectation that the JSNA be carried out jointly by the director of public health, director of adult social services and director of children's services.

1.2 The government has since highlighted the 'equal and explicit' role of GP consortia and local authorities, including the director of public health, in preparing the JSNA, and endorsed the JSNA's key role in informing joint health and wellbeing strategies, to be developed by new Health and Wellbeing Boards.

1.3 The aim of the JSNA is to deliver an understanding of the current and future health and wellbeing needs of the population over both the short term (three to five years), and the longer term future (five to ten years) to inform strategic planning commissioning services and interventions that will achieve better health and wellbeing outcomes and reduce inequalities.

1.4 The JSNA is an evidence based document highlighting need, as such it is distinct from the **Health & Wellbeing Strategy** which it informs and which arises from it. The Health & Wellbeing Strategy outlines the priorities (based on the JSNA) agreed by the Health & Wellbeing Board together with the proposed actions and expected outcomes.

2. REASON FOR REPORT GOING TO HEALTH & WELLBEING BOARD

2.1 At its meeting in September the Health and Wellbeing Board (HWB) agreed that it would receive regular updates on the progress in completing the annual JSNA to increase knowledge which will assist in informing the HWB priorities.

2.2 This report therefore describes the process for undertaking the 2013/14 JSNA, the suggested areas that will be covered and the key milestone dates and actions.

2.3 The report also outlines the proposed approach for completing the 2013 refresh of the current Health and Wellbeing Strategy.

2.4 The Health and Wellbeing Board is asked to comment and agree the approach outlined for:
- updating the 2014 JSNA including the new areas outlined in section 4.1 and the timescales for undertaking;
- refreshing the current Health & Wellbeing Strategy to reflect the previous 2012/13 JSNA

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

3.1 Whilst the Public Health Team within the LB Bromley have the lead responsibility for completing the JSNA a project steering group has been established with representatives from:
- Education & Care Services including adult social care, children's social care and education
- CCG Clinical Lead
- Voluntary Sector Strategic Network
- Community Links Bromley
- Healthwatch Bromley
- Environmental Services, LA Housing and LA Planning

Health & Wellbeing Strategy

The JSNA is an evidence based document highlighting need, as such it is distinct from the Health & Wellbeing Strategy which it informs. The Health & Wellbeing Strategy outlines the priorities (based on the JSNA) agreed by the Health & Wellbeing Board together with the proposed actions and expected outcomes.

Financial

1. Cost of proposal: within existing resources
2. Ongoing costs: within existing resources – core business
3. Total savings (if applicable): not applicable
4. Budget host organisation: LBB
5. Source of funding: Approved 2013/14 ECHS Budget
6. Beneficiary/beneficiaries of any savings: not applicable

Supporting Public Health Outcome Indicator(s)

The JSNA will record progress against the Public Health Outcome Indicators.

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4. COMMENTARY

4.1 What the 2013/14 is likely to include?

The aim of the JSNA is to deliver an evidenced based understanding of the current and future health and wellbeing needs of the population over both the short term (three to five years), and the longer term future (five to ten years) to inform strategic planning commissioning services and interventions that will achieve better health and wellbeing outcomes and reduce inequalities.

The table below shows the topic areas the Steering Group have suggested be included in this year's JSNA. The core areas are those included in previous years, and these will be updated. In 2014 there will be a number of new areas:

- The ward health profiles will show the levels of a range of health outcome indicators for each ward and provide a comparison between wards.

- There will be a report on the characteristics and health needs of those people who use unscheduled care services frequently.

- The section on Asset Based Community Development will focus on the principles of asset based community development, a framework for using assets, examples of how this approach has been used in Bromley. The aim is for this section to be developed further in subsequent years.

Area	**Core/ New/**
The Health of People in Bromley: Life Expectancy and the Burden of Disease	Core
The Places where People Live • Ward Health Profiles • Housing	 New Core
Populations of Interest (Each of these sections include a summary of the health needs of the relevant population). • Children & Young People • Older People • Learning Disability, Physical Disability & Sensory Impairment and mental health and wellbeing • End of Life Care • Carers • Alcohol and Substance Misuse • Frequent Attenders to Unscheduled Care Services	 Core Core Core Core Core Core New
Asset Based Community Development	New
Reports on more in depth health needs assessments carried out during the year – up to 5 can be undertaken	Core
Updates on issues raised in the last JSNA	Core

Full details and examples can be found in Appendix 1.

4.2 How will this be undertaken?

The Steering Group will oversee the production of the JSNA and act as an advocate for the JSNA process. Members will nominate leads for specific sections.

A working group has been set up to include the leads for specific sections. These leads will collate routine and non-routine information and set the context in narrative.

The final document and Executive Summary will be published on the JSNA page on the Bromley MyLife web portal. A web presence for the underlying JSNA data is being developed further this year.

4.3 Key Milestones

Scope for the 2014 JSNA developed and agreed	November 2013
Data collected, collated, and analysed	December 2013 to April 2014
Sections drafted, proofs produced and document edited	December 2013 to April 2014
Draft JSNA circulated to stakeholders for comment	May to July 2014
Final editing and updating of core data (where appropriate)	August 2014
JSNA finalised, signed off by HWB and published	September 2014
Underlying JSNA data published on web	September 2014
HWB prioritise areas for two health needs assessments	September 2014
HWB considers JSNA and prioritises key areas	October – December 2014
New HWB Strategy & Work Plan developed by HWB	October 2014 – February 2015
2015 – 18 HWB Strategy approved and published	March 2015

4.4 Proposed Approach for refreshing the 2012 – 15 Health & Wellbeing Strategy

It is proposed that the current strategy will be reviewed by end of December to reflect the last JSNA signed of the HWB in July 2013. The current nine priorities will be revisited and updated as appropriate. The draft refreshed strategy could then be presented to the January HWB meeting for approval.

This approach could then enable the HWB to consider the revised JSNA in autumn 2014 to underpin the new 2015 HWB strategy and HWB work plan priorities. The benefit of this approach is that it will enable the HWB to develop shared priorities which then can be reflected within the strategy.

Non-Applicable Sections:	**FINANCIAL IMPLICATIONS; LEGAL IMPLICATIONS IMPLICATIONS FOR OTHER GOVERNANCE ARRANGEMENTS, BOARDS AND PARTNERSHIP ARRANGEMENTS**
Background Documents: (Access via Contact Officer)	

Appendix 1 - Proposed Outline for JSNA 2013-14

The Health of People in Bromley: Life Expectancy and the Burden of Disease (2012 JSNA from page 22)

This section will look at the demography of the population and will summarise the key causes of mortality and the prevalence, trends and issues for the key diseases and risk factors for disease.

The Places where People Live (2012 JSNA from page 98)

- **Ward Health Profiles**

  This section will include a map of each ward with information on key health indicators for that ward, as well as a ranking of the ward against the other wards in the borough for each indicator.

- **Housing**

  This section will summarise the key issues relating to housing and health in the Borough.

Populations of Interest (2012 JSNA from page 126)

Each of these sections will include a summary of the health needs of the relevant population.

- Children & Young People
- Older People
- Learning Disability
- Physical Disability & Sensory Impairment
- Mental Health
- End of Life Care
- Carers
- Substance Misuse
- Alcohol
- Frequent Attenders to Unscheduled Care Services

Asset Based Community Development (new)

This section will focus on the principles of asset based community development, a framework for using assets, examples of how this approach has been used in Bromley. This section will be developed further in subsequent years.

Reports on more in depth needs assessments carried out during the year

Updates on Progress from Last Year's JSNA (2012 JSNA from page 229)

http://bromley.mylifeportal.co.uk/uploadedFiles/Putting_People_First/Bromley_Homepage/Document_Library/Public_Health/BROMLEY%20JSNA%202012%20FINAL%20VERSION.pdf

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London Borough of Bromley

PART ONE - PUBLIC

HEALTH AND WELLBEING BOARD

Date: **Thursday 28 November 2013**

Report Title: **INTEGRATION TRANSFORMATION FUND (ITF) 2015/16**

Report Author: Richard Hills, Education Care & Health Services London Borough of Bromley
Tel: 0208 313 4198 E-mail: richard.hills@bromley.gov.uk

1. SUMMARY

1.1 The Spending Round 2013 announced a pooled budget of £3.8 billion for local health and care systems in 2015/16. This is now being referred to as the "Integration Transformation Fund" (ITF).

1.2 The fund is intended to support an increase in the scale and pace of integration. It is clearly also a mechanism for promoting joint planning for the sustainability of local health and care economies against a background of significant savings targets right across the system.

1.3 Although announced as if new money into the health and care system this pooled fund is, in the main, created through top slicing existing budgets. Top slicing Clinical Commissioning Group (CCG) budgets will make up over 65% of the fund, the rest is made up from top slicing the Local Authority budget and adding the existing Department of Health (DoH) Social Care Grant which now is subsumed into ITF.

2. REASON FOR REPORT GOING TO HEALTH & WELLBEING BOARD

2.1 Access to the Integration Transformation Fund in 2015/16 will be dependent on agreement of a local 2-year plan for 2014/15 and 2015/16. The plans will need to be agreed jointly by the Local Authority and Bromley's Clinical Commissioning Group and then signed off by the Health and Wellbeing Board before being submitted to NHS England by February 2014.

2.2 A template has been produced nationally for local areas to complete their submissions. The template sets out the key information and metrics that Boards will need to assure themselves that their plans address in order to meet the conditions of the ITF.

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

- That the H&WB is aware of the immediate implications of ITF and that the Board has a key role in overseeing the Local Plan

- That the timeframes available to us locally are extremely tight and so Board is asked to agree that this joint working be a key priority for both the CCG and Local Authority throughout December in order that a draft plan can be presented back to the Board in January.

- That the Board recognises that this is a likely model for government funding of the health and care economy in the future

Health & Wellbeing Strategy

1. Related priority: As this impacts on the direct local funding of health and care it relates to all the priorities in the Health and Wellbeing Strategy. The two year Local Plan requested by NHS England will need locally to reflect the priorities identified by the H&WB in their strategy.

Financial

1. Cost of proposal: The allocation for individual boroughs will not be announced until 4th December but the ITF pooled fund is likely to be in the region of £6m for the planning year in 2014/15 and in the region of £15m in Bromley for 2015/16..

2. Ongoing costs: This fund is the result of top slicing existing budgets and so core services on both sides already rely on this funding. The Local Plan will need to be very clear about what the ITF will be used to fund locally.

3. Total savings (if applicable): At this stage these are unknown but there is an expectation that integration results in efficiencies in the health and care system which will result in alleviating growing cost pressures.

4. Budget host organisation: Unclear – an approved Local Plan triggers a release of the funding by NHS England but at this stage there has been no information about how it will be managed locally.

5. Source of funding: NHS England

6. Beneficiary/beneficiaries of any savings:

Supporting Public Health Outcome Indicator(s)

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4. COMMENTARY

There will be a presentation at the Board to highlight the main points and summarise the information that both the CCG and LA are currently receiving from The Department of Health and other bodies such as London Councils, ADASS and NHS London about what we have to do locally and any support being made available.

5. FINANCIAL IMPLICATIONS

The ITF represents both an opportunity and challenge for both organisations, both of whom are being pressed to find significant savings over the next 5 years.

Only when officers from both the CCG and LA have worked up a draft proposal using the national ITF template will we be in a position to quantify the financial implications in detail.

6. LEGAL IMPLICATIONS

None. Unless agreement cannot be reached locally over the content of the local plan and what the ITF will fund. NHS England are considering how regional support would be given if such a situation was to arise.

7. IMPLICATIONS FOR OTHER GOVERNANCE ARRANGEMENTS, BOARDS AND PARTNERSHIP ARRANGEMENTS, INCLUDING ANY POLICY AND FINANCIAL CHANGES, REQUIRED TO PROGRESS THE ITEM

Given the potential impact on existing funding arrangements, both the Local Authority and Clinical Commissioning Groups will need to gain the approval of their respective local Executives before finalising a draft ready for the Health and Wellbeing Board.

8. COMMENT FROM THE DIRECTOR OF AUTHOR ORGANISATION

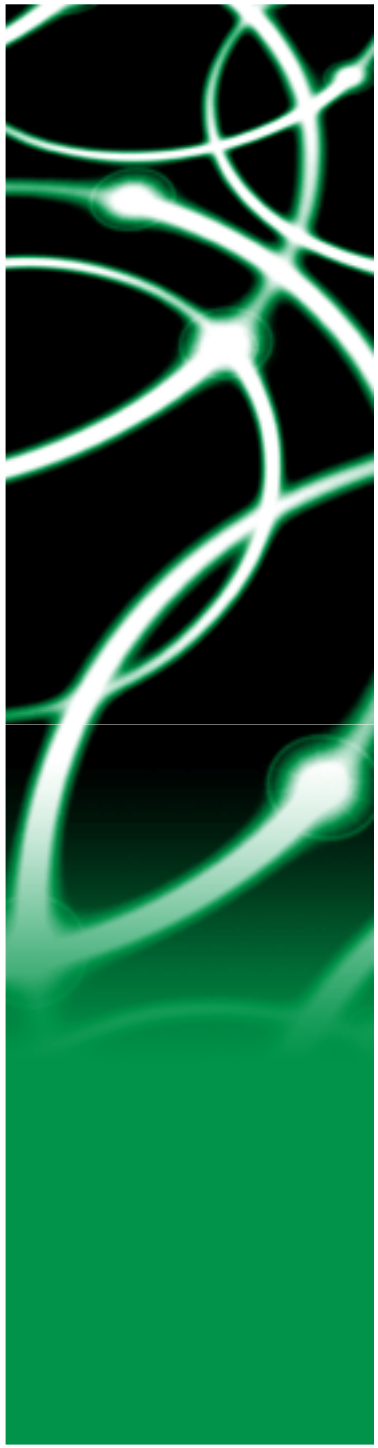
I have read and support this report, both in terms of its contents and actions.

I would also refer H&WB Members to the Executive report listed below, which includes more detail on the expectations placed on local government and Clinical Commissioning Groups by the Department of Health regarding the use of this new Integrated Transformation Fund.

Non-Applicable Sections:	
Background Documents: (Access via Contact Officer)	ADULT SOCIAL CARE – IMPACT OF THE CARE BILL AND FUTURE NHS FUNDING – report to Executive by the Executive Director of Education, Care and Health Services 20th November

Bromley ITF Presentation

Richard Hills – Strategic Commissioner



ITF – What is it?

"The 'Integration Transformation Fund' is a single pooled budget for health and social care services to work more closely together in local areas.

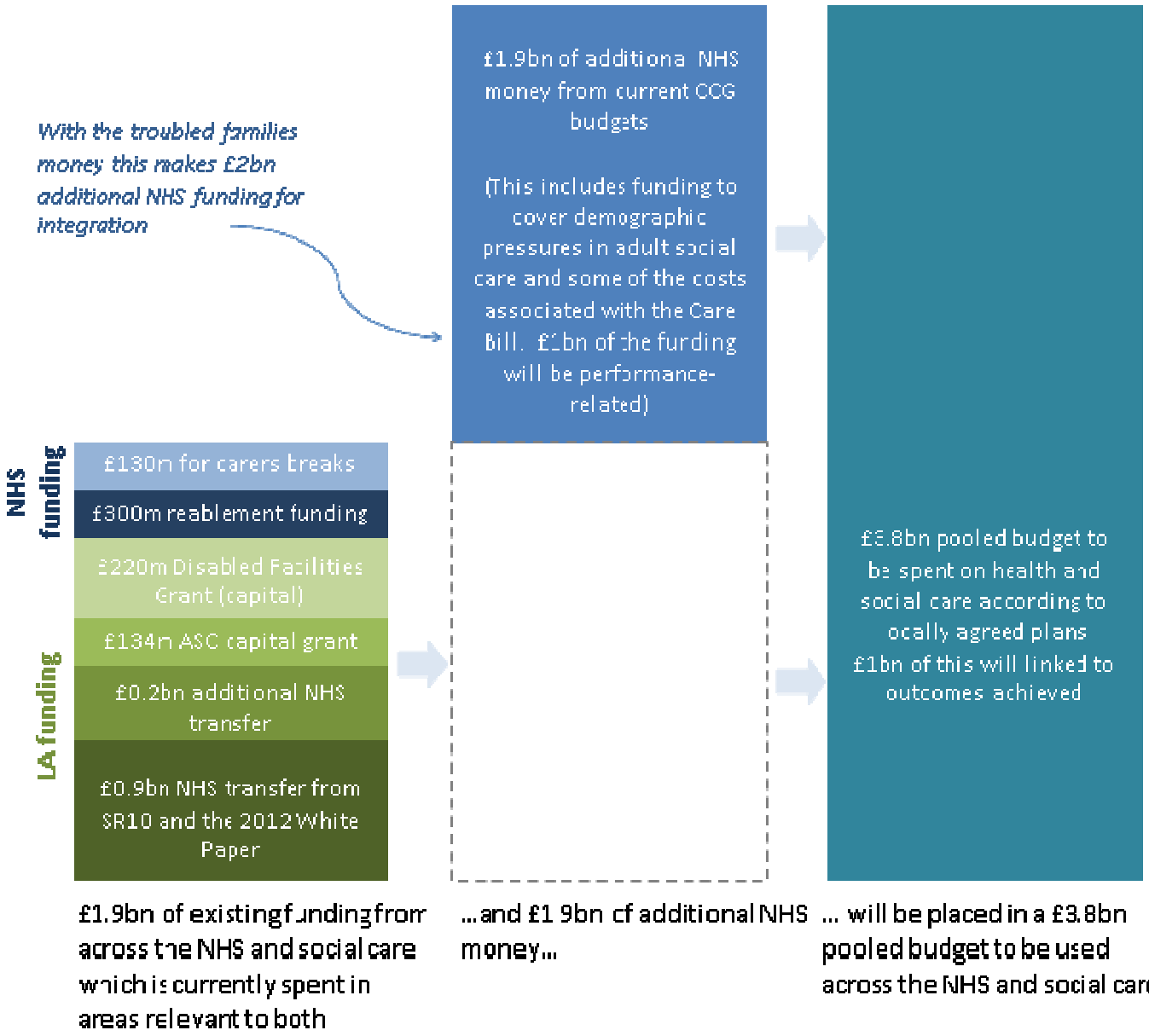
The fund is an important catalyst for change, moving more towards preventative, community-based care to help to keep people out of hospital and in community settings for longer. That's in the interest of the individual and the public purse."

- LGA & NHS England

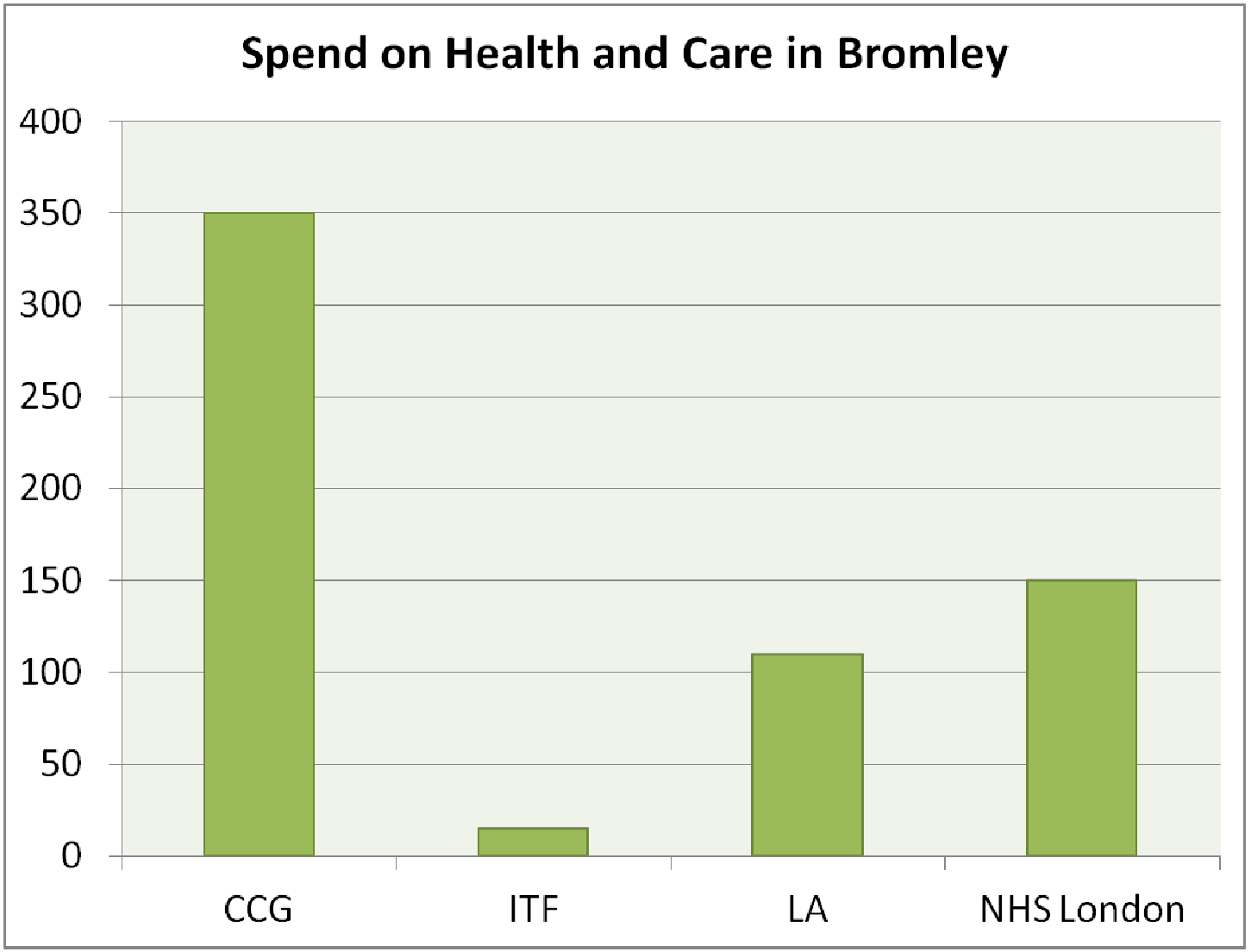
ITF - The Pooled Pot

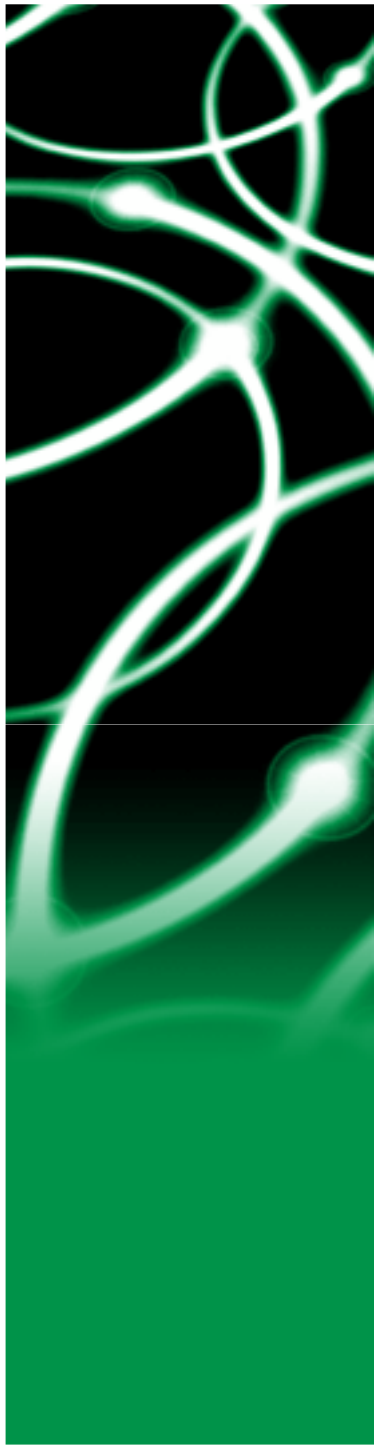
- £3.8bn announced by Chancellor in the Autumn spending round
- Actually £1.1bn in 14/15 (Planning Year)
- Full £3.8bn in 15/16
- Recycled funding already in the system
- Top slicing existing CCG and LAs budgets (65% CCG – 35% LA)

What makes up the Pot?



A pooled pot of around £15m locally





How do we access the funding?

…We can't, at least not individually!

Instead we have to:

- Produce a Joint 2-year 'Local Plan'
- Agreed by both CCG & LA Executives
- Health & Wellbeing Board (30th Jan)
- Submitted to NHS London (14th Feb)
- Extremely tight timeframes LAs/CCGs will need to build in engagement with service providers and users during the planning year 14/15

What's the 'must haves'?

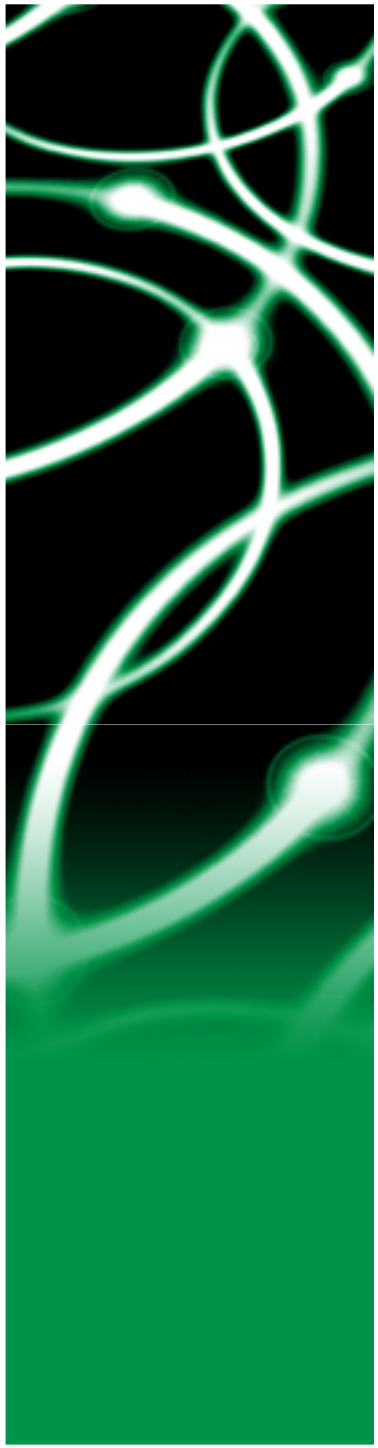
Four National Conditions:

1) Protecting Social Care Services
2) 7 day service to support discharge
3) Data Sharing via NHS number
4) Joint-Assessments & accountable professional

Two other Principles:

1) Risk-sharing and contingency plans if targets are not met
2) Agreement on the impact of changes in the acute sector

…25% of the 15/16 funding is performance related and likely to be directly linked to meeting these objectives.



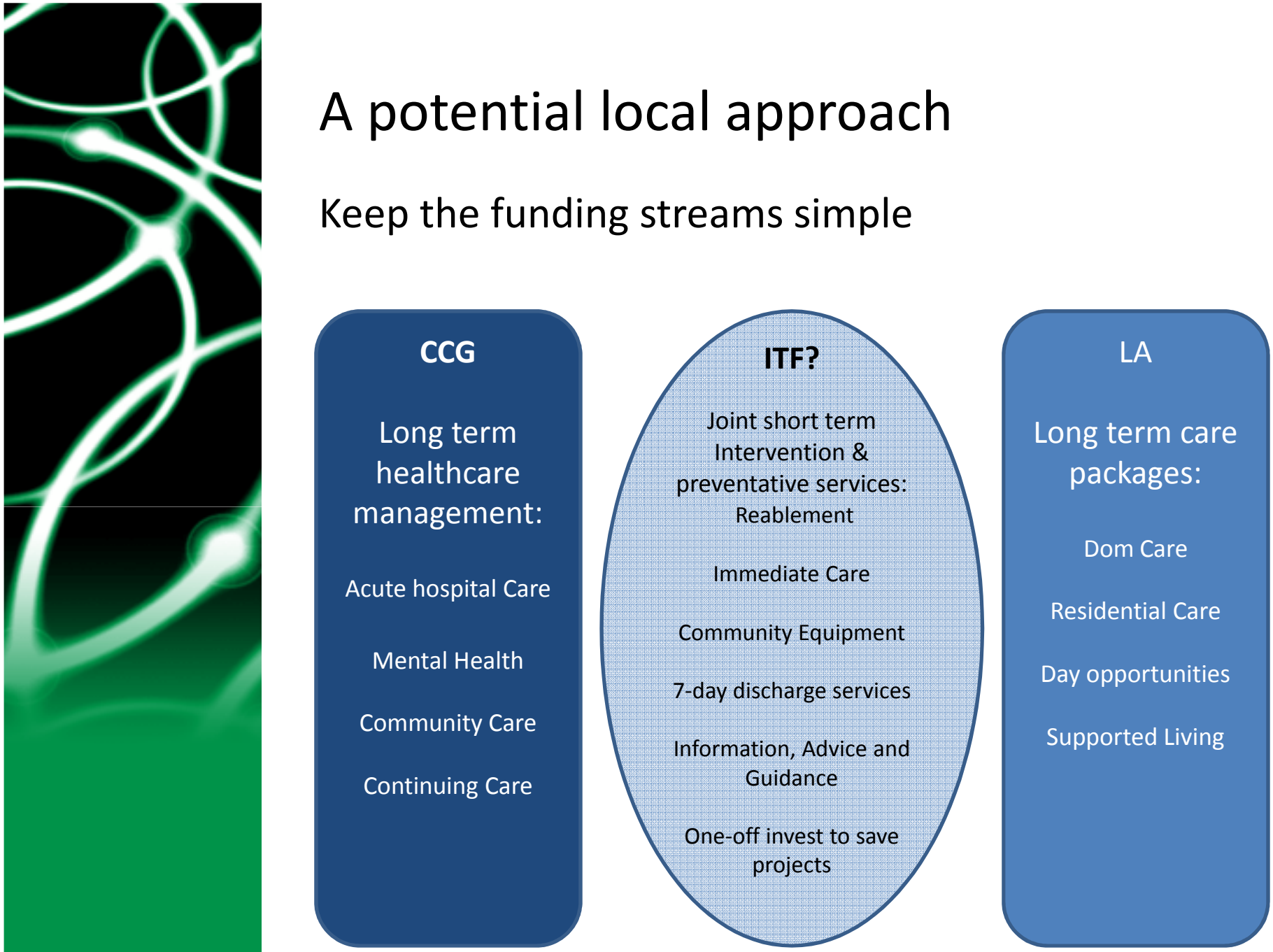
Measures still to be decided

…likely to be nationally:

- Delayed transfers of care
- Emergency admissions
- Effectiveness of reablement
- Admissions to residential & nursing care
- Patient & service user experience

A potential local approach

Keep the funding streams simple



Advantages locally for ITF

- Forces us to look quicker and in more depth at integration
- A set of integrated services around short term Health & Care interventions and preventative services
- A clear area of focus for H&WB strategic oversight
- Simpler to budget and account for where ‘whole’ services are funded through ITF
- Easier to identify targeted outcomes from ITF spend against national and local indicators
- Delivers on new duties in the Health and Care Act and upcoming Care Bill…not only conditions in ITF

London Borough of Bromley

PART ONE - PUBLIC

HEALTH AND WELLBEING BOARD

Date:	**Thursday 28 November 2013**
Report Title:	**ProMISE (Proactive Management of Integrated Services for the Elderly) Programme Three year expenditure plan**
Report Author:	Paul White, Associate Director of Development & ProMISE Programme Director, Bromley Clinical Commissioning Group Tel: 01689 880567 E-mail: paul.white@bromleyccg.nhs.uk

1. SUMMARY

1.1 In 2012, Bromley Clinical Commissioning Group developed its first three-year Integrated Commissioning Plan, outlining the priority areas for shaping and delivering healthcare to the people of Bromley. Long-term conditions and care for older people was identified as one of six strategic programmes that constituted the plan; 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.

1.2 Radical cultural, operational and service change is required to achieve our ambition and central to the ProMISE programme is a determination to systematically change the way in which health and social care is delivered.

1.3 The primary aim of ProMISE is to shift the requirement of unplanned care delivered in an acute (secondary care) setting, after reacting to an unpredicted health crisis, to a more proactive approach.

1.4 The overarching principles behind the work rest upon our ability to prevent this group of 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 offer individualised case management in a community setting with a range of additional support services aimed at maintaining and improving their current health.

1.5 Since April, the programme has progressed markedly. We are beginning to see tangible benefits of the many component enabling projects. We are building a system that anticipates, identifies and responds to individual needs and 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.

1.6 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.

2. REASON FOR REPORT GOING TO HEALTH & WELLBEING BOARD

2.1 The challenge of providing health and social care for an ageing and growing population, within limited resources is well-documented and is one of the principal motives behind this initiative. Bromley's Joint Strategic Needs Assessment (JSNA) details the borough's specific demographic trends and key disease challenges typically associated with the elderly.

2.2 Latest demographic figures quote the Bromley registered population of 312,3541. The JSNA 2012 estimates a rise to 326,217 by 2017 and 332,956 by 2022. Elderly people represent 17.6% of Bromley residents (2011), equating to 54,000; the greatest concentration of elderly in London. It is expected that this will increase to 57,000 (an increase of 5%) by 2015 and will continue to increase to 74,100 (37%) by 2030.

2.3 With residents living longer, greater pressure is being put on the system. As demonstrated in the Joint Strategic Needs Assessment (JSNA), the implications of this are:

- Increased demand on healthcare & increased costs
- Increased demand on social care & increased costs
- A greater number of complex packages required with multi-agencies, which are likely to be more costly on already restrained budgets

2.4 Key disease challenges for the area relate to heart disease, diabetes, respiratory disease and dementia:

- Over the past 6 years the prevalence of hypertension has been rising, with Bromley being above national average.
- Similarly the number of patients with Diabetes is increasing, which is particularly significant given it is a precursor to heart disease or stroke.
- Respiratory conditions are prevalent in the area also and represent almost 13% of total deaths in Bromley, including influenza and chronic obstructive pulmonary disease.
- Dementia is becoming increasingly more prevalent with an increase in the over 65s population and further emphasis is required to identify and treat the condition.

2.5 Latest JSNA figures quote 4,100 people living in Bromley with dementia, and with the ageing population the incidence of dementia is set to rise by 4% (159 people) by 2015 and will continue to increase by 47% (1,945 people) by 2030.

2.6 However, the predominant concerns are the continuous rise in numbers of resident with diagnoses of high blood pressure and type-2 diabetes.

2.7 Due to the complexity and extent of co-morbidities of elderly patients, this cohort prove to be both high activity users, regularly accessing GP practices, hospitals, clinics, social services, community care and pharmacies.

2.8 The ProMISE programme aims to address many of the challenges and the identified priorities within the Health & Wellbeing Strategy: Diabetes, Hypertension, Anxiety & Depression, Dementia and Supporting Carers.

[1] Taken from Registered patient data from 1/1/2012 provided by Bromley CCG Informatics Team

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

3.1 The programme budget for ProMISE stands at £7.5 million and is held under a Section 256 agreement with the London Borough of Bromley.

3.2 The purpose of this report is to:

- provide an update, in accordance with the terms of the Section 256 agreement - updating the three-year investment programme and reporting on progress with its constituent projects;
- seek Health & Wellbeing Board support for the release of funds specific to programme related activities in 2013/14 - subject to ratification by the Executive of the Local Authority
- seek Health & Wellbeing Board support for the planned expenditure in 2014/15 and 2015/16, recognising that whilst there may be subsequent revisions to the breakdown of the investments these will not result in a material change to the overall expenditure plan - subject to ratification by the Executive of the Local Authority; and
- note that the Health & Wellbeing Board will continue to receive regular progress reports.

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4. COMMENTARY

The following summarises progress being made against each of the defined projects within the programme and the measurable impact of the investments being made, where available:

- Case Management – twenty-one 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 (still being validated) of 418 patients supported in this way suggests that this is having a significant impact on their demand for secondary care services:

Year on year financial comparison for ProMISE patient cohort (418 patients)

	Apr 2012 to July 2012		Apr 2013 to July 2013		Variation	
	Activity	**Spend**	**Activity**	**Spend**	**Activity**	**Spend**
A&E	282	£42,523	178	£26,230	-104	-£16,292
Inpatient Emergency	214	£590,624	91	£228,326	-123	-£362,298
Outpatient First	216	£51,006	116	£22,169	-100	-£28,837
Outpatient follow-up	369	£42,838	269	£33,185	-100	-£9,653
Total	**1081**	**£726,991**	**654**	**£309,910**	**-427**	**-£417,081**

This four month activity comparison relates to 18 GP practices covering 52% of the Bromley registered population

This information is still being validated but if accurate, as we believe, and extrapolated to Bromley-wide the full year effect in terms of avoided secondary care activity and spend could be:

	Activity	Spend	Activity	Spend	Activity	Spend
A&E	1627	£245,323	1027	£151,329	-600	-£93,994
Inpatient Emergency	1235	£3,407,446	525	£1,317,265	-710	-£2,090,181
Outpatient First	1246	£294,266	669	£127,898	-577	-£166,369
Outpatient follow-up	2129	£247,142	1552	£191,450	-577	-£55,692
Total	6237	£4,194,177	3773	£1,787,941	**-2463**	**-£2,406,235**

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 often already know 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 reconfiguring its services to work in six co-located locality teams with effect from 2 December. 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 will shortly be introducing 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. We are working with local authority colleagues with a view to bringing a similarly dedicated and ideally 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.

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 will be accepting referrals from GP practices into their newly commissioned service from 25 November and from other healthcare professionals from January. 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 will be commencing a newly commissioned enhanced end of life care service from the start of December. They will be 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; 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.

  More than 30 GP practices have enrolled and patients are being signed up to the self-monitoring scheme. 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 almost 250 applications for training and already three UTIs have been identified in residential care homes, which if left untreated would most likely have led to hospital admission and, given the age of the patients (105.100 and 85) may have led to prolonged stays and further complications. We intend to continue to market and run free training sessions for the remainder of this year and throughout 2014/15.

5. FINANCIAL IMPLICATIONS

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 spread sheet included with this report (Appendix A) summarises the £7.5 million programme expenditure plan for 2013 to 2016. A detailed breakdown of all expenditure on a month by month basis for each individual project is available should any member require it.

The spread sheet also encompasses the net savings assumptions associated with this programme. The savings are those anticipated from shifting the requirement of unplanned care delivered in an acute (secondary care) setting after reacting to an unpredicted health crisis, through the act of forecasting individual patient needs for care and support which can be delivered in the community (primary care) and the service user's own home.

There is increasing evidence of the benefits of proactively helping people to stay well and at home wherever possible for both the individuals and their families in terms of quality of life and outcomes and in terms of reducing emergency bed days. However, there may be concern that this

approach will create other cost pressures across the local health and social care economy. Any discernible evidence of the impact on social care and other services to date has been highlighted, in section 4 below,

The savings that this programme generate in conjunction with the Integration Transformation Fund should support further investment in out of hospital services, where appropriate and evidenced, as part of the ongoing strategy to transform the way that health and social care services are delivered.

The savings that the different projects under this programme generate can be reinvested across Bromley's health and social care system in support of the prevention agenda and to reduce our reliance on high cost, long term bed-based care. Funding will continue to be realigned to develop and support out of hospital services, where appropriate and evidenced, as part of the ongoing strategy to transform the way that health and social care services are delivered.

This one-off programme spend on Promise puts Bromley in a strong position and compliments the upcoming work required locally by the CCG and London Borough of Bromley to deliver a two year local plan for the use of the Integrated Transformation Fund (ITF).

6. LEGAL IMPLICATIONS

Nothing to add further to section 5 above.

7. IMPLICATIONS FOR OTHER GOVERNANCE ARRANGEMENTS, BOARDS AND PARTNERSHIP ARRANGEMENTS, INCLUDING ANY POLICY AND FINANCIAL CHANGES, REQUIRED TO PROGRESS THE ITEM

None identified.

8. COMMENT FROM THE DIRECTOR OF AUTHOR ORGANISATION

I have read and support this report, both in terms of its contents and recommendations.

Appendix A

NEW SERVICES	2013 -14 ProMISE £0's	2014-15 ProMISE £0's	2015-16 ProMISE £0's	All years ProMISE £0's	CCG Budgets £0's	Full Year CCG £0's	13-14 Gross QIPP £0's	14-15 Net QIPP £0's	15-16 Net QIPP £0's
Case Management & Integrated Care									
Project investments	£150,000	£1,137,000	£1,137,000	£2,424,000	£0	£1,137,000			
Projected Savings Gross	-£180,000	-£1,449,000	-£1,210,000	-£2,839,000	-£1,694,000	-£2,904,000			
Projected Savings Net	-£30,000	-£312,000	-£73,000	-£415,000	-£1,694,000	-£1,767,000	-£180,000	-£132,000	-£1,455,000
Falls Project									
Project investments	£100,424	£301,273	£75,318	£477,015	£225,955	£301,273			
Projected Savings	-£36,941	-£773,677	-£209,102	-£1,019,720	-£627,306	-£836,408			
Projected Savings Net	£63,483	-£472,404	-£133,784	-£542,705	-£401,351	-£535,135	-£36,941	-£435,463	-£62,731
Diabetes									
Project investments	£103,846	£395,258	£344,834	£843,938	-£193,595	£459,779			
Projected Savings	-£25,007	-£529,473	-£580,784	-£1,135,264	-£387,190	-£774,379			
Projected Savings Net	£78,839	-£134,215	-£235,950	-£291,326	-£580,784	-£314,600	-£25,007	-£109,208	-£682,519
End of Life									
Project investments	£103,542	£310,627	£155,314	£569,483	£155,316	£310,632			
Projected Savings	-£146,061	-£1,130,793	-£565,397	-£1,842,250	-£565,397	-£1,130,793			
Projected Savings Net	-£42,518	-£820,166	-£410,083	-£1,272,767	-£410,081	-£820,161	-£146,061	-£674,105	0
Teleheath/medicine									
Project investments	£28,000	£16,500	£16,500	£61,000	£0	£11,500			
Projected Savings	-£14,000	-£42,000	-£42,000	-£98,000	£0	-£42,000			
Projected Savings Net	£14,000	-£25,500	-£25,500	-£37,000	£0	-£30,500	-£14,000	£0	£0
Patient Liaison Officer									
Project investments	£0	£0	£0	£0	£0	£0			
Projected Savings	£0	£0	£0	£0	£0	£0			
Projected Savings Net	£0	£0	£0	£0	£0	£0	£0	£0	£0

UTI									
Project investments	£7,000	£4,013	£4,013	£15,026	£0	£4,013			
Projected Savings	-£77,906	-£306,516	-£306,516	-£690,938	£0	-£306,516			
Projected Savings Net	-£70,906	-£302,503	-£302,503	-£675,912	£0	-£302,503	-£77,906	-£224,597	£0
TOTALS									
Project investments	**£492,813**	**£2,164,671**	**£1,732,979**	**£4,390,463**	**£187,676**	**£2,224,197**			
Projected Savings	**-£479,915**	**-£4,231,459**	**-£2,913,799**	**-£7,625,173**	**-£3,273,892**	**-£5,994,096**			
Projected Savings Net	**£12,897**	**-£2,066,788**	**-£1,180,820**	**-£3,234,710**	**-£3,086,216**	**-£3,769,899**	**-£479,915**	**-£1,575,373**	**-£2,200,250**
INVEST TO SAVE & START UP COSTS							£475,389		
Case Management/Integrated Care (community matrons, integrated care pilot, community teams, risk software & training)	£613,600	£225,300	£400,000	£1,238,900	£0	£0			
Falls Project (includes GP register scheme)	£202,944	£31,200	£0	£234,144	£0	£0			
Diabetes (training of GP staff)	£119,202	£183,740	£55,290	£358,232	£0	£0			
End of Life (includes community equipment & rapid discharge service)	£211,960	£142,979	£0	£354,940	£0	£0			
Teleheath/medicine (includes licences, SMS messages and GP practice training)	£57,350	£0	£0	£57,350	£0	£0			
Patient Liaison Officer Scheme (GP practice staff training)	£29,225	£0	£0	£29,225	£0	£0			
UTI (consumables & carer training)	£31,200	£31,200	£0	£62,400	£0	£0			
Fixed Costs (Overheads) - All Projects	£342,873	£215,388	£215,388	£773,649	£0	£0			
Total Management & other Project Investments	**£1,608,354**	**£829,807**	**£670,678**	**£3,108,840**	**£0**	**£0**			
Total Investment	**£2,101,167**	**£2,994,478**	**£2,403,657**	**£7,499,302**					