BROMLEY CIVIC CENTRE, STOCKWELL CLOSE, BROMLEY BRI 3UH

THE LONDON BOROUGH
www.bromley.gov.uk

TELEPHONE: 020 8464 3333
CONTACT: Kerry Nicholls
*kerry.nicholls@bromley.gov.uk*

DIRECT LINE: 020 8313 4602
FAX: 020 8290 0608

DATE: 25 October 2016

To: Members of the
**HEALTH SCRUTINY SUB-COMMITTEE**

Councillor Judi Ellis (Chairman)
Councillor Pauline Tunnicliffe (Vice-Chairman)
Councillors Ruth Bennett, Kevin Brooks, Mary Cooke, Hannah Gray, David Jefferys, Terence Nathan, Catherine Rideout and Charles Rideout QPM CVO

Non-Voting Co-opted Members

Linda Gabriel, Healthwatch Bromley
Justine Godbeer, Bromley Experts by Experience
Rosalind Luff, Carers Forum
Lynn Sellwood, Voluntary Sector Strategic Network

A meeting of the Health Scrutiny Sub-Committee will be held at Bromley Civic Centre on **WEDNESDAY 2 NOVEMBER 2016 AT 4.00 PM**

MARK BOWEN
Director of Corporate Services

***Copies of the documents referred to below can be obtained from http://cds.bromley.gov.uk/***

**A G E N D A**

**1 APOLOGIES FOR ABSENCE AND NOTIFICATION OF SUBSTITUTE MEMBERS**

**2 DECLARATIONS OF INTEREST**

**3 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 Thursday 27th October 2016.

**4 MINUTES OF THE MEETING OF HEALTH SCRUTINY SUB-COMMITTEE HELD ON 8TH JUNE 2016 AND MATTERS ARISING** (Pages 3 - 12)

**5 PRUH IMPROVEMENT PLAN - UPDATE FROM KING'S FOUNDATION NHS TRUST (PRESENTATION)**

**6 MENTAL HEALTH REHABILITATION REDESIGN - OXLEAS (PRESENTATION)** (Pages 13 - 26)

**7 OXLEAS RELOCATION OF LD SERVICES** (Pages 27 - 30)

**8 OVERVIEW OF PHARMACY SERVICES IN BROMLEY - CCG (PRESENTATION)**

**9 PLANS FOR FRAILTY SERVICE AT ORPINGTON HOSPITAL - CCG (PRESENTATION)**

**10 JOINT HEALTH SCRUTINY COMMITTEE - CHAIRMAN'S UPDATE** (Pages 31 - 36)

**11 WORK PROGRAMME 2016/17** (Pages 37 - 40)

**12 ANY OTHER BUSINESS**

**13 FUTURE MEETING DATES**

4.00pm, Thursday 9th March 2017

.....

# HEALTH SCRUTINY SUB-COMMITTEE

Minutes of the meeting held at 4.00 pm on 8 June 2016

**Present:**

Councillor Judi Ellis (Chairman)
Councillor Pauline Tunnicliffe (Vice-Chairman)
Councillors Ruth Bennett, Kevin Brooks, Ellie Harmer and David Jefferys

Linda Gabriel, Healthwatch Bromley

**Also Present:**

Councillor Diane Smith, Executive Support Officer to the Portfolio Holder for Care Services

## 1 APOLOGIES FOR ABSENCE AND NOTIFICATION OF SUBSTITUTE MEMBERS

Apologies for absence were received from Councillor Hannah Gray, Councillor Terry Nathan, Councillor Catherine Rideout, Councillor Charles Rideout CVO QPM, Councillor Robert Evans and Councillor Mary Cooke, and Councillor Ellie Harmer attended as her substitute.

Apologies were also received from Justine Godbeer and Lynn Sellwood.

Apologies were received from Councillor David Jefferys and Councillor Pauline Tunnicliffe for leaving the meeting early at, respectively, 5.15pm and 5.25pm due to alternate commitments.

## 2 DECLARATIONS OF INTEREST

Councillor Judi Ellis declared that her daughter worked for South London and Maudsley Foundation Trust (SLaM) and that she was a governor of Oxleas NHS Foundation Trust.

Linda Gabriel declared that she was the Chair of Bromley & Lewisham Mind.

## 3 QUESTIONS FROM COUNCILLORS AND MEMBERS OF THE PUBLIC ATTENDING THE MEETING

No questions had been received.

## 4 MINUTES OF THE MEETING OF HEALTH SCRUTINY SUB-COMMITTEE HELD ON 4TH NOVEMBER 2015 AND 25 FEBRUARY 2016 AND MATTERS ARISING

Linda Gabriel, Healthwatch Bromley requested that her apologies for absence be recorded for the meeting held on 4th November 2015.

**RESOLVED that the minutes from the meetings held on 4th November 2015 and 25th February 2016 be agreed, subject to the amendment outlined above.**

## 5 JOINT HEALTH SCRUTINY COMMITTEE - UPDATE

The Chairman provided an update on Our Healthier South East London – Joint Health Overview and Scrutiny Committee which had met on 26th April 2016 and 17th May 2016 to consider the range of health services across the South East London region.

The Committee had identified the need to develop a clear definition of the role of an Urgent Care Centre and an Accident and Emergency Department to support patients in accessing the most appropriate level of care for their health needs. Work was also being undertaken to compile a list of health provision across South East London to provide clarity on the services available.

With regard to the potential for two units to be maintained across the South East London region to deliver planned care, the Committee was reviewing the continued provision of day surgery and outpatient services on the Orpington Hospital site, as well as possible provision at Queen Mary's Hospital, Sidcup, and this would be discussed at the next meeting.

The minutes of the meeting of the Joint Health Scrutiny Committee held on 17th May 2016 would be circulated to Members of the Sub-Committee when available.

**RESOLVED that the update be noted.**

## 6 PRUH IMPROVEMENT PLAN - UPDATE FROM KING'S FOUNDATION NHS TRUST

The Sub-Committee received a presentation from Paul Donohoe, Deputy Medical Director, Princess Royal University Hospital (PRUH) and Sarah Willoughby, Stakeholder Relations Manager, King's College Hospital NHS Foundation Trust providing an update on the progress of the Trust and the PRUH Improvement Plan.

An organisational restructure was being undertaken in a number of planned phases to redesign structures and embed skilled 'can do' teams across the Trust. A Transformation Programme was also in progress which was a long-term project which aimed to ensure services were high quality, focused on patients and fit for the future, and that strategic aims around productivity were achieved.

Performance across the Trust had been impacted by the Norovirus outbreak at the Princess Royal University Hospital (PRUH) during Spring 2016. This had affected performance against the Accident and Emergency four hour 95%

target, with 81%, 83.5% and 85% achieved, respectively, at the PRUH in March, April and May 2016. There had been a steady improvement in this performance throughout 2016/17 and the figure for June 2016 was currently at 90%. Finances for the Trust continued to improve with £65m of savings achieved during 2015/16 which had met the savings target, and a new savings target of £50m had been agreed for 2016/17. A new Chief Operating Officer, Jane Farrell, was now in post and a new Director of Capital, Estates and Facilities, Jane Bond, would join the Trust later in 2016.

In terms of performance, the Standardised Mortality Rate at the PRUH had dropped in 2015/16 to the 10th lowest out of 136 Trusts which was in the top 8% of performance. Patient experience ratings had also increased to 93% in March and April 2016 which exceeded the benchmark of 89%. A recruitment drive was underway for additional Consultants in areas such as Accident and Emergency, Medicine and Surgery, and a Job Fair had also been held in April 2016. The new cross-site Electronic Patient Record system would roll out from July 2016 at the Denmark Hill and Orpington sites and from September 2016 at the PRUH.

Progress continued in delivering the Emergency Care Pathway Programme which took a whole system approach to helping patients get the right care in the right way. All workstreams were being reviewed to identify key pieces of work that would effect maximal change and a Transfer of Care Evaluation Workshop would be held on 10th June 2016. In considering demand and capacity, unplanned admissions had increased since 2013/14 and despite a reduction in the length of stay, this had created a bed pressure and high occupancy level which had limited the PRUH's ability to respond to surges in patients requiring emergency admission. To address this, the Trust was working with system regulators and local commissioners to meet demand in coming months and was also undertaken a redesign of patient pathways.

With regard to the Norovirus outbreak at the PRUH, the first outbreak had been identified on 9th February 2016 and had continued until the first week of April 2016. A second outbreak had been detected on 15th April 2016 which had continued until the end of May 2016. Overall 200 beds had been affected, with 40 out of 500 available beds lost at the peak of the outbreak. Members were advised that the design of the PRUH had made it challenging to contain the outbreak due to the easy access between wards and insufficient clinical sinks at entry points to clinical areas and wards. The outbreak had affected discharges to Nursing and Residential Homes which resulted in blocked beds and restricted movement across the admission pathway, and issues had also been identified around the transportation of samples to Denmark Hill which had delayed the reopening of affected bays in some cases. Actions taken to respond to the outbreak had included a review of all affected wards by the Infection, Prevention and Control team at least three times a day, multi-team operational meetings to review and plan for each ward, and a strict implementation of the visiting policy. Enhanced cleaning had taken place on affected wards, additional resources and laboratory testing had been provided, and there had also been a focus on improving hand hygiene compliance through increased audits and mobile

sinks. An update on this would be provided to Members at the next meeting of the Sub-Committee.

Members were generally concerned at how the design of the PRUH had made it difficult to contain the Norovirus outbreak. The Deputy Medical Director advised Members that a post-outbreak review meeting had been planned for 24th June 2016 where learning could be identified and areas for action agreed. This was likely to include an increase in hand hygiene facilities, possible on-site PCR testing for Norovirus, and closer linking with community teams around admission and discharge.

In response to a question from the Chairman, the Deputy Medical Director reported that Consultants and other medical staff had worked hard to maintain a good level of service for patients during the recent strike action by Junior Doctors, and that the learning from this experience, including the efficiencies realised by Consultants working more closely together would be reviewed to identify best value processes.

A Member was pleased to note the introduction of the cross-site Electronic Patient Record system which would support better access to patient records as well as more timely discharge processes, and underlined the benefits of access to patient records across all health partners to ensure that patients received the most appropriate level of care for their health needs. The Deputy Medical Director confirmed that work was being progressed to integrate the Electronic Patient Record system with primary care providers, and that an update would be provided to Members at the next meeting of the Sub-Committee.

The Chairman raised the issue of quotas for patient discharge and highlighted the need for patients to be discharged at a reasonable time with appropriate support in place, and that it could be distressing where the date of discharge was changed. The Deputy Medical Director explained that patients had an estimated date of discharge which could change dependent on the health of the patient, and that it was important for this to be communicated clearly to the patient and their family. The Assistant Director: Adult Social Care reported that the evaluation of the Transfer of Care Bureau would include discharge processes and identify potential improvements.

In response to a question from the Chairman regarding changes to pathology services, the Deputy Medical Director noted that work was being undertaken to ensure pathology services available to the PRUH and primary care providers were fit for purpose, and that an update would be provided to Members at the next meeting of the Sub-Committee.

The Chairman led Members in thanking Paul Donohoe and Sarah Willoughby for their excellent presentation.

**RESOLVED that the update be noted.**

## 7 PHLEBOTOMY REVIEW - CCG

The Sub-Committee received an update from Dr Angela Bhan, Chief Officer, Bromley Clinical Commissioning Group on the outcome of a review of Phlebotomy services which had recently been undertaken across the region and included both hospital services and those provided by GPs.

The review identified that a very good service was available at six GP practices across the Borough, and consideration was being given to how Phlebotomy services could be procured into the future in a way which did not disrupt this high quality service provision and which worked closely with Pathology services. To support this, significant additional resources had been identified to secure a high quality provision across the overall system, and the Bromley Clinical Commissioning Group was working with a number of different providers on how this process might best be managed. It was hoped that the new system would be in place from January 2017, and a second phase was also planned which would explore the possible centralisation of some services.

**RESOLVED that the update be noted.**

## 8 TRANSFER OF CARE BUREAU - SIX MONTH EVALUATION - CCG

The Sub-Committee received an update from Dr Angela Bhan, Chief Officer, Bromley Clinical Commissioning Group on the results of a six month evaluation of the Transfer of Care Bureau which had been established to enable better cooperation between all agencies in providing a comprehensive approach to complex discharges from the PRUH.

The independent review had been undertaken by Transformation Nous in April 2016 and identified that since the introduction of the Transfer of Care Bureau there had been a reduction of 5% in the number of long-staying spells and the bed days occupied, that at any point of time there were approximately 80 ‘medical stable for transfer of care’ (MSFT) supported discharges in hospital beds, and that on average the system had supported the transfer of care of 225 patients from the PRUH to the community every month, 80% of whom were Bromley patients.

Key areas for improvement included the need to take a more parallel approach to the discharge process to avoid delays between agencies, for care managers to take proactive ownership of the discharge process, and issues caused by Transfer of Care Bureau staff having to work with the three different information systems for hospital, social care and community services which was causing duplication of work. There was also a need for an agreed set of metrics to be developed in relation to the new MediNet hospital information system, which would support reporting processes.

In considering the update, the Chairman was concerned that some patients might experience issues following discharge, and that measures should be in

place to reduce any deterioration in people's health whilst they waited for reassessment. Dr Angela Bhan reported that less than 5% of discharged patients were readmitted, and that the aim was for people to be supported in the community by Integrated Care Networks.

Additional resources had been identified through the Better Care Fund to work with care homes to recognise and meet the increasing health and care needs of care home residents over time before a point of crisis was reached, as well as to help them feel confident in supporting residents with enhanced care packages as their needs increased and with end-of-life care. The need to engage carers and families more in care plans had also been identified.

The Chairman noted the importance of promoting the new emphasis on care in a community setting to Bromley residents as well as outlining the cost implications of increased care needs as people grew older, particularly for home owners. Advice was available via the Bromley Council website, but the potential to reach a wider audience, such as through Borough-wide mailings or the annual Council Tax statement should also be considered.

In response to a question from a Co-opted Member, Dr Angela Bhan confirmed that Integrated Care Networks took a holistic view of people's health and care needs. Work was being undertaken with GPs to identify those patients at risk of admission to hospital or who had complex needs, and for whom a care plan could be developed which would support the management of their needs within the community. The Transfer of Care Bureau also took a complete overview of patient's health and care needs as part of the discharge process.

**RESOLVED that the update be noted.**

## 9 EVALUATION OF WINTER SERVICES - CCG

The Sub-Committee received an update from Dr Angela Bhan, Chief Officer, Bromley Clinical Commissioning Group on the outcome of the evaluation of winter services.

Bromley Clinical Commissioning Group had worked in collaboration with a number of urgent care system partners to implement initiatives during Winter 2015/16 which aimed to provide additional urgent care capacity in times of surge, aid the achievement of the 95% Accident and Emergency four hour target and offer the best possible care for residents of Bromley through a historically challenging season.

The impact of each scheme was not always measurable, however a number of the schemes had had a positive impact. This included the provision of in-reach staff at the PRUH to redirect patients to the most appropriate care provision, changes to supported discharge to better enable transfer of care and to increase capacity of community-based support services, and additional capacity for mental health liaison staff.

**RESOLVED that the update be noted.**

## 10 SE LONDON SUSTAINABILITY & TRANSFORMATION PLAN - CCG

The Sub-Committee received an update from Dr Angela Bhan, Chief Officer, Bromley Clinical Commissioning Group on progress in developing the South East London Sustainability & Transformation Plan. This was a five year plan centred on the needs of the local population which brought health and care partners together to determine how services would evolve and become sustainable over the next five years, and achieve three main aims which comprised reducing inequalities in health and wellbeing across South East London, reducing variations in quality of healthcare delivered to the population and ensuring that finances were stable into the future.

In developing the South East London Sustainability & Transformation Plan, Bromley had benefitted from the longstanding working relationships between local health providers and was acting as an 'example' for the rest of the country. A range of measures had been identified to reduce a projected deficit of over £1b by 2021. This included asking all health providers to deliver a sustainable cost improvement programme of 1.6% each year, for acute providers to work together to improve collective productivity, and for new models of working to be introduced. The move towards community-based care through integrated care networks would be key to realising financial savings, as was work to improve people's life chances by supporting them further into healthier zones. Joined-up pathways through health would also provide a better offer to the local population.

The Chairman underlined the need to undertake community engagement as part of the process of developing and implementing the South East London Sustainability & Transformation Plan, and requested that regular updates be provided to Members as appropriate.

The Chairman also noted the potential for individual Trusts in the South East London region to work together, and Members were advised that three Health Trusts in the area were seeking to take a collaborative rather than competitive approach to service provision, such as in workforce costs and agency spend.

The deadline for the South East London Sustainability & Transformation Plan to be submitted to NHS England was 30th June 2016, with a view to implementation from Autumn 2016.

**RESOLVED that the update be noted.**

## 11 BROMLEY HEALTHCARE QUALITY ACCOUNT 2015/16

**Report CSD16088**

*The Chairman moved that the attached report, not included in the published agenda, be considered as a matter of urgency on the following grounds:*

*There is a requirement for the quality accounts of all health providers to be endorsed by the Local Authority and to be submitted to NHS England by 30th June 2016.*

Natalie Warman, Director of Nursing, Therapies and Quality, Bromley Healthcare and Julie Miller, Clinical Quality Team Manager, Bromley Healthcare presented the Bromley Healthcare Quality Account 2015/16 to the Sub-Committee, which outlined the provision delivered by Bromley Healthcare across the Borough during 2015/16 and quality priorities for 2016-2020. There was a statutory requirement for all NHS public funded bodies to provide their Annual Quality accounts to NHS England for publication by 30th June 2016, and for this to contain a supporting statement from the Health Scrutiny Sub-Committee.

The Director of Nursing, Therapies and Quality confirmed that the quality priorities for 2016-2020 would be informed by the South East London Sustainability and Transformation Plan and Local Care Networks, and that work would be undertaken in parallel with these initiatives. Bromley Healthcare had developed three key commitments to patients, carers and staff which comprised knowing each patient's story and what mattered to them, ensuring their care was delivered by the right staff with the right skills at the right place and time, and to meet the health needs of the community at the greatest possible value.

The Sub-Committee generally agreed that the Bromley Healthcare Quality Account 2015/16 was an accurate account of service provision, parts of which had been scrutinised by the Care Services PDS Committee and the Health Scrutiny Sub-Committee during 2015/16, and noted the areas identified for future improvement between 2016-2020 and how the implementation of this would be monitored.

The Chairman was pleased to note the emphasis Bromley Healthcare placed on valuing and developing its staff, and that Bromley Healthcare was developing an education and training programme to assist people to build a career within community health services in the Borough. This included work with Bromley College of Further and Higher Education to promote careers within health and social care, and the creation of work placements for students and apprentices.

A Co-opted Member highlighted that Bromley Healthcare met every six weeks with Healthwatch Bromley which supported good communication and closer links between Bromley residents and Bromley Healthcare.

**RESOLVED that the Bromley Healthcare Quality Account 2015/16 be supported by the Health Scrutiny Sub-Committee.**

## 12 WORK PROGRAMME 2016/17

**Report CSD16064**

Members considered the forward rolling work programme for the Health Scrutiny Sub-Committee. The Chairman requested that Members notify the clerk of any additional items to be added to the work programme.

**RESOLVED that the work programme be noted.**

## 13 ANY OTHER BUSINESS

There was no other business.

## 14 FUTURE MEETING DATES

4.00pm, Wednesday 2nd November 2016
4.00pm, Thursday 9th March 2017

The Meeting ended at 6.15 pm

Chairman

This page is left intentionally blank

**Report No.**
**CS17071**

**London Borough of Bromley**

**PART ONE - PUBLIC**

---

| | |
|---|---|
| **Decision Maker:** | **Health Scrutiny Sub-Committee** |
| **Date:** | **2nd November 2016** |
| **Decision Type:** | Non-Urgent Non-Executive Non-Key |
| **Title:** | **MENTAL HEALTH REHABILITATION REDESIGN** |
| **Contact Officer:** | Adrian Dorney, Associate Director, Inpatient and Crisis Services<br>Oxleas NHS Foundation Trust<br>Tel: 0208 836 8517 |
| **Ward:** | Borough-wide |

---

1. Reason for report

1.1 This report outlines the redesign of the Mental Health Rehabilitation pathway by Oxleas NHS Foundation Trust which seeks to modernise the pathway and re-balance inpatient and community rehabilitation services.

1.2 The redesign involves investment in the development of multi-disciplinary community rehabilitation services to provide care for patients in their own homes and avoid the need for admission to inpatient rehabilitation settings, and to assist those who are in an inpatient rehabilitation setting to move back to more independent settings. It also seeks to reduce the number of inpatient rehabilitation beds that are required, with the reduction in inpatient beds allowing for the re-investment in community rehabilitation services to support the lower bed base.

1.3 An Equality Impact Assessment is provided with the report attached at **Appendix A**.

---

2. **RECOMMENDATIONS**

2.1 Members of the Health Scrutiny Sub-Committee are requested to note the redesign of the Mental Health Rehabilitation pathway.

Impact on Vulnerable Adults and Children

1. Summary of Impact: An Equality Impact Assessment is provided with the report attached at Appendix A.

---

Corporate Policy

1. Policy Status: Not Applicable
2. BBB Priority: Not Applicable: Oxleas NHS Foundation Trust service provision.

---

Financial

1. Cost of proposal: Not Applicable: The redesign is cost-neutral
2. Ongoing costs: Not Applicable:
3. Budget head/performance centre: N/A
4. Total current budget for this head: £N/A
5. Source of funding: N/A

---

Personnel

1. Number of staff (current and additional): There will be reduction of health posts as a result of the proposed change, but there will be no reduction in social care staffing. Staff consultation has been undertaken in line with required standards.
2. If from existing staff resources, number of staff hours: N/A

---

Legal

1. Legal Requirement: Not Applicable
2. Call-in: Not Applicable

---

Procurement

1. Summary of Procurement Implications: N/A

---

Customer Impact

1. Estimated number of users/beneficiaries (current and projected): All Bromley servicer users.

---

Ward Councillor Views

1. Have Ward Councillors been asked for comments? Not Applicable
2. Summary of Ward Councillors comments: N/A

## 3. COMMENTARY

3.1 This report outlines the redesign of the Mental Health Rehabilitation pathway by Oxleas NHS Foundation Trust which seeks to modernise the pathway and re-balance inpatient and community rehabilitation services.

3.2 The redesign involves investment in the development of multi-disciplinary community rehabilitation services to provide care for patients in their own homes and avoid the need for admission to inpatient rehabilitation settings, and to assist those who are in an inpatient rehabilitation setting to move back to more independent settings. It also seeks to reduce the number of inpatient rehabilitation beds that are required, with the reduction in inpatient beds allowing for the re-investment in community rehabilitation services to support the lower bed base.

## 4. IMPACT ON VULNERABLE ADULTS AND CHILDREN

4.1 Patients who continue to require inpatient rehabilitation will continue to receive care within these settings. All patient moves will be conducted appropriately in line with their clinical needs. Some patients may be moved from Ivy Willis House to Barefoot Lodge. The Trust has contacted all patients and their carers on the redesign changes, and meetings have been offered to all involved. An Equality Impact Assessment is provided with the report attached at **Appendix A.**

## 5. FINANCIAL IMPLICATIONS

5.1 There are no financial implications. The redesign is cost neutral.

## 6. PERSONNEL IMPLICATIONS

6.1 Staff consultation has been undertaken in line with required standards. There will be a reduction of health posts as a result of the proposed change but there will be no reduction in Social Care staffing. The reduction of health staffing will see qualified and non-qualified staff move from working in inpatient settings to either community rehabilitation or to other posts within the Trust.

| **Non-Applicable Sections:** | Policy, Legal and Procurement Implications |
|---|---|
| Background Documents: (Access via Contact Officer) | Rehabilitation Summary Briefing<br>2nd November 2016<br>(Report Supplied) |

This page is left intentionally blank

improving lives

Oxleas NHS
NHS Foundation Trust

# Rehabilitation Summary Briefing
# 2nd November 2016

## Introduction

This review has been focussed on consideration of the balance of services in the pathway across inpatient, step down and community provision. The focus of this service redesign is to deliver a rehabilitation service which provides a more balanced provision of different levels of rehabilitation across inpatient and community settings. This will allow patients to receive care within the right setting for their level of need and enable a more seamless patient journey on the clinical pathway.

A higher provision in supported accommodation and community rehabilitation will allow more patients to be treated closer to home or in their own homes.

The redesign of rehabilitation services is an exciting opportunity to modernise provision structures to deliver a more balanced provision within the pathway which is line with good practice on recovery and care closer to home outside of institutions.

## Development of Rehabilitation Pathway

The key developments to improve the rehabilitation pathway are:

- Maintain appropriate level of Inpatient Rehabilitation
- Establish Community Rehabilitation services
- Increase the level of Supported Accommodation

**Maintain appropriate level of Inpatient Rehabilitation**
It is acknowledged that in order to provide a comprehensive rehabilitation pathway it is necessary to maintain an amount of provision at each stage of the pathway. As such it is appropriate to maintain a level of inpatient rehabilitation provision whilst reducing the volume of this service.

Current inpatient caseloads include a number of patients who are treated within the inpatient setting for longer than is clinically necessary due to lack of availability of step down options such as community rehabilitation and supported housing.

There are also times when patients are referred to inpatient rehabilitation due to the absence of other options even though their needs could be met closer to home in less restrictive environment. We know that referral levels into inpatient rehab have remained relatively stable since 2013 and that the majority of referrals come from acute inpatient services (see Appendix 1). One of the negative impacts of this is that patients will inevitably lose their own tenancies as a result of moving into long term inpatient care and it is very difficult to secure future tenancies once lost.

**Establish Community Rehabilitation**
Re-investment of resources from inpatient rehabilitation settings into Psychiatry and Multi disciplinary staffing, to enable service users to be supported in their own homes.

This staffing resource will be able to support the transition of service users stepping down from Supported Accommodation and work with third sector providers to increase the level of need they are able to support.

This staffing resource will also be able to support service users who require rehabilitation but do not require this to be delivered in an inpatient or supported accommodation setting. This may be transitioning service users out of MH acute admission or supporting service users in their own homes in order to avoid a MH acute admission.

The Community Rehabilitation resource will be in a position to gradually step down their input as the service user progresses, transitioning service users into MH Community Teams or back to Primary Care as appropriate.

**Increase the level of Supported Accommodation**
Re-investing with third sector to develop increased provision within supported accommodation will provide an increased level of provision for step down of service users from inpatient rehabilitation.

This increased provision will also provide an alternative option for patients that require rehabilitation but do not have the level of need that requires this rehabilitation to be delivered within an inpatient setting. This will reduce the demand on high cost inpatient rehabilitation.

The level of need that third sector supported accommodation providers will be able to support will be enhanced by the input of Community Rehabilitation resource, including Psychiatry, Nursing, Psychology, Occupational Therapy and Social Work.

It is envisaged that within Bexley this will involve the expansion of the currently provided DISH service. A process of tender will be necessary within boroughs to identify providers to work in partnership with.

## Rehabilitation Model

The shift toward ‘personalisation’ and direct payments in Social Care Services and the increasing focus on supporting people in their own homes requires changes in how we offer services to ensure that the social inclusion agenda is integral to service delivery.

Increasingly, services are appropriately geared towards non institutional care. In order to ensure that service users receive the right care, at the right time in the right place, we will need to develop affinity with an active rehabilitation model within the services to allow the appropriate throughput of service users in all stages of the pathway as soon as clinically appropriate.

Over the last 2 years the inpatient rehabilitation units work has been undertaken to ensure that service users receive care within rehabilitation units for only as long as clinically indicated.

By re-investing in community rehabilitation staffing resource we will be able to deliver these interventions to service users at all stages of the rehabilitation pathway.

The development of consistent active rehabilitation models in line with good practice across the three boroughs is essential to deliver effective rehabilitation to those whose needs require it.

The focus of the inpatient rehabilitation model will be on short to medium term rehabilitation, provided within 18 months to 2 years, with the possibility of some care exceeding this period in certain cases in line with Community Rehabilitation and High Dependency Rehabilitation good practice guidelines. (Royal College of Psychiatrists, 2009)

After this period it is expected that any further required rehabilitation would continue within less intensive step down supported accommodation as appropriate.

In order to achieve a more consistent model and manage a lower rehabilitation bed base it is necessary to ensure that only those who have the most complex needs enter inpatient rehab and effective throughput is achieved.

The community rehabilitation staffing resource will work to support transition of service users from inpatient services to step down provision.

In line with the approach of "right care, right time, right place" the pathway out of inpatient rehabilitation will look to fully utilise step down / move on accommodation to enable service users to transfer to lower supported settings as soon as it is clinically appropriate. This will maximise independence and promote recovery while avoiding service users remaining in high support rehabilitation setting longer than clinically necessary.

Inpatient rehabilitation is not a clinical model which offers home/care for life. The provision of supported accommodation is fundamental to the rehabilitation pathway with continued rehabilitation work being led by community services.

Good practice guidance highlights that commissioning good rehabilitation services includes ensuring that there are the appropriate components and levels of care provided to support the rehabilitation pathway, these include supported accommodation services – providing day to day support for service users to live in the community, supported tenancies and floating outreach services. (Joint Commissioning Panel for Mental Health, 2012)

The provision of Community Rehabilitation services from the re-investment monies will allow for Psychiatrist and MDT input to both the supported living services and to service users in their own homes.

**Community Rehabilitation Service Model / Pathway:**

- Please see Appendix 2 for pathway

- Provide Inpatient Rehabilitation for only the most complex and enduring need. Increase levels of supported accommodation / DISH type provision.

- Facilitate the treatment of more patients outside of inpatient rehabilitation with the delivery of more intensively supported Community Rehabilitation within supported accommodation / DISH type services.

- Community Team Care Coordinator involved at every stage of the pathway

- Combining input from secondary care Community Rehabilitation MDT services and third sector providers.

- Intensity of input from Community Rehab services dictated by needs, reducing as recovery progresses.

- Psychiatrist to clinically manage care into Community Rehabilitations Service / supported accommodation. Continuity of clinical care across the pathway.

- Patients supported via Care Coordinators in Community Teams with Community Rehab MDT

- Community Rehab MDT available to provide the more intensive support required for community rehabilitation.

- Community Rehab MDT reducing input as recovery progresses, remaining with Care Coordinator in ICM / ADAPT, pathway towards PCP / Primary Care.

- Peer Support / Lived Experience Practitioners – provide input as part of the Community Rehabilitation Service

- Out of hours support by supported living staff and Oxleas staff via Home Treatment Teams / UAL

- Support joint working with voluntary sector agencies that provide supported housing and work opportunities. Link with Recovery Colleges.

- Around half the NHS Trusts in England, have a community rehabilitation service. The community rehabilitation service can give more specialised support than the more generic community mental health teams. In other parts of the United Kingdom, approaches to rehabilitation and recovery may be different.

## Rehabilitation Development Proposal

The focus of this service redesign is to deliver a rehabilitation service which provides a more balanced provision of different levels of rehabilitation across inpatient and community settings. This will allow patients to receive care within the right setting for their level of need and enable a more seamless patient journey on the clinical pathway.

In order to achieve the required service development the following changes are necessary:

- Close Somerset Villa, Ivy Willis House Open and Closed units
- Maintain Barefoot Lodge as Inpatient rehab unit
- Reinvest funding in Community rehab / third sector provision

Barefoot Lodge will be maintained as the inpatient rehabilitation service for the Bexley, Bromley and Greenwich. This service will provide 15 beds which will be accessed on a cross borough basis, as is currently the practice.

A project group has been established to take forward the proposed service development.

A tender will be under taken to establish sufficient supported accommodation provision for each borough.

The changes will effect shift pattern nursing staff currently employed within the inpatient rehabilitation services. Psychiatry and MDT staffing, Occupational Therapists, Psychologists and Social Workers currently working within inpatient rehabilitation will be assigned to the community rehabilitation resource along with an a nursing contingent as appropriate / necessary.

As a result of these changes, no patients will be referred for local authority funded services unless it is part of their care plan, as the most suitable option in their clinical care / pathway.

The requirement to meet cost efficiency savings for the year 2016/17 will be met by this service development.

## Summary

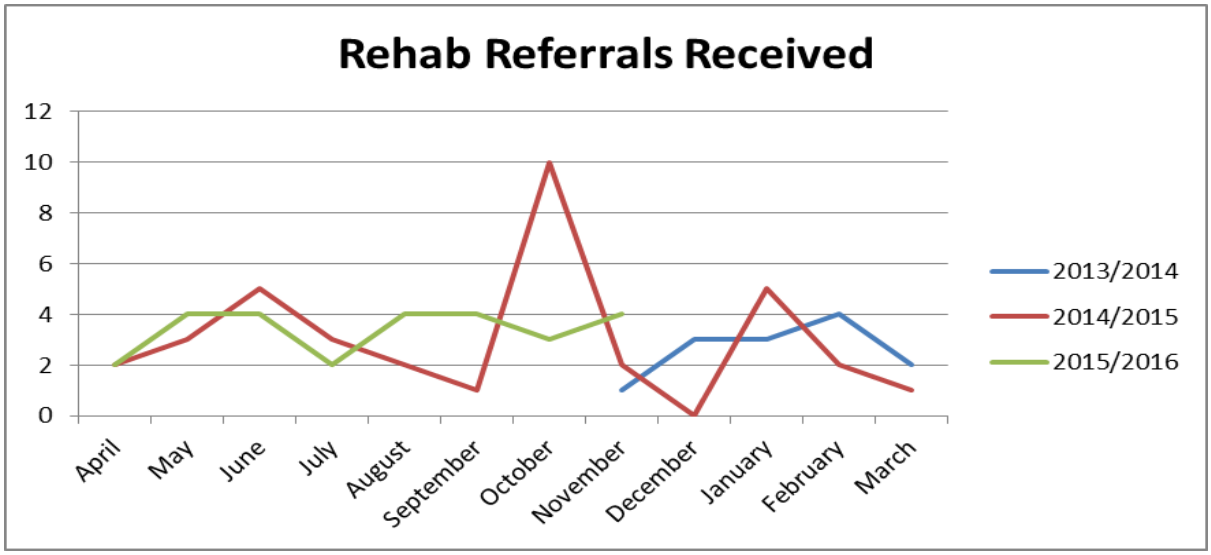
Improvements to the Rehabilitation service clinical pathway will allow patients to access the right level of support at the right time and enable patients to be better supported towards more independent living in a staged manner.

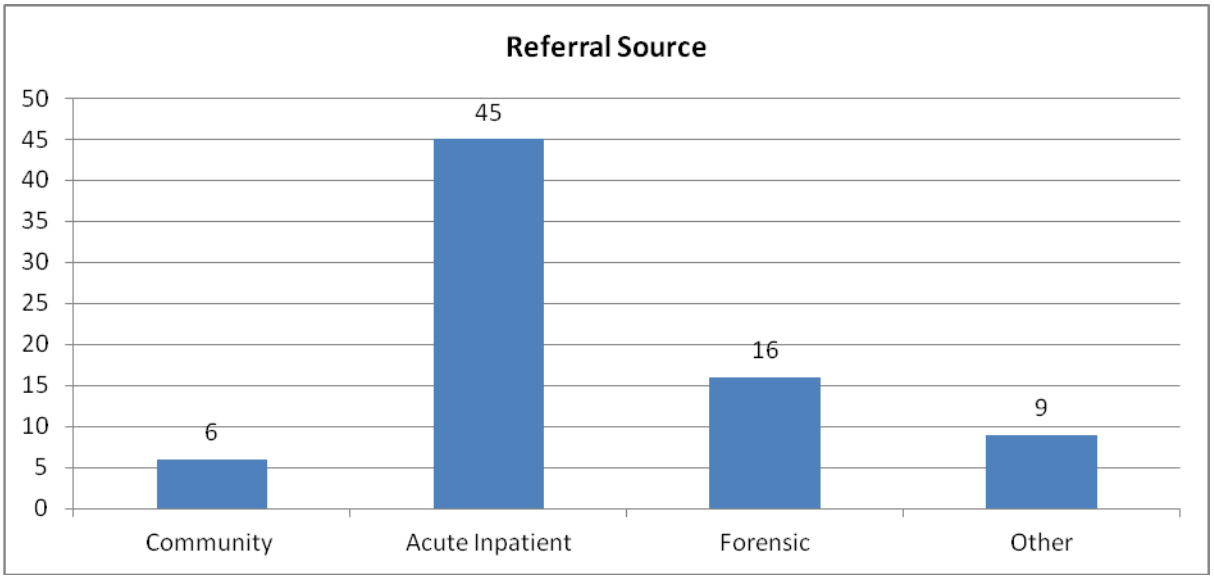
A higher provision in supported accommodation and community rehabilitation will allow more patients to be treated closer to home or in their own homes.

The redesign of rehabilitation services is an exciting opportunity to modernise provision structures to deliver a more balanced provision within the pathway which is line with good practice on recovery and care closer to home outside of institutions.

# Appendices

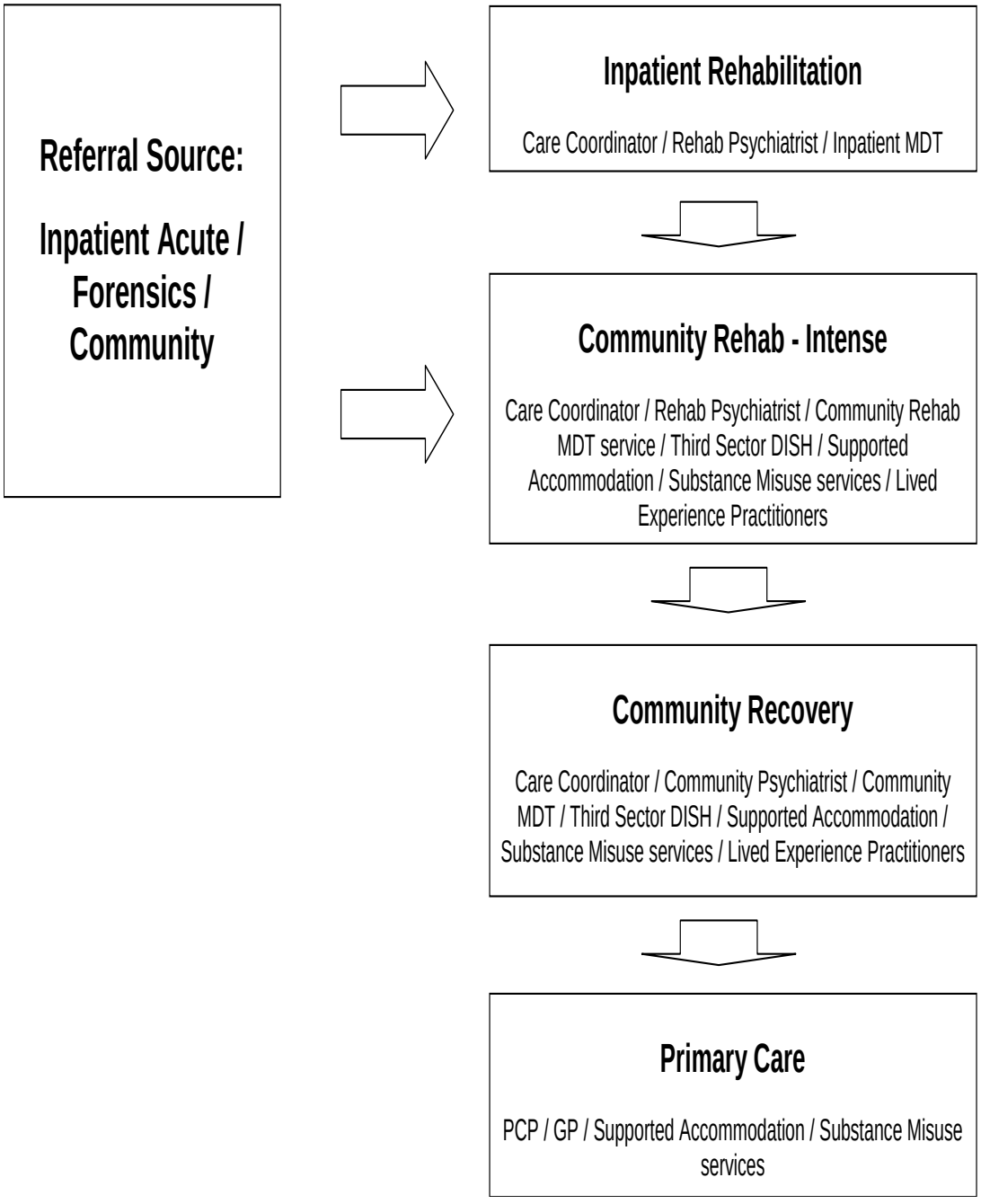
## Appendix 1



## Appendix 2

# Rehabilitation Care Pathway



# Appendix 3

## Equality Impact Assessment
## Service Change
## Equality Analysis

| |
|---|
| **Service(s) Under Review Adult Mental Health Rehabilitation Services** |
| **Date of Equality Analysis: 28.7.16 Amended 08.09.16** |
| **Timescale for proposed changes: October 2016 – April 2017** |
| **Equality Analysis Lead Person & Job Title: Darren Ward Service Manager** |
| **Overview of Current Service:**<br>There are 4 in-patient rehabilitation units across the 3 boroughs, Barefoot Lodge, Somerset Villa, Ivy Willis Open and Ivy Willis closed.<br><br>**Overview of proposed Service changes:**<br><br>3 of the units will close: Ivy Willis Open, Ivy Willis closed and Somerset Villa.<br>A community based provision will be provided in all 3 boroughs. |
| **Will the proposals affect service users, staff or both?**<br><br>Both |
| **1. What is the impact of your service review or proposed change (positive and/or negative) in relation to the following protected characteristics:**<br>▪ **Age**<br>▪ **Disability**<br>▪ **Ethnicity**<br>▪ **Gender**<br>▪ **Sexual Orientation**<br>▪ **Religion/Belief**<br>▪ **Pregnancy/maternity**<br>▪ **Transgender** |
| **Service users:** It may be that a small number of patients will be transferred to another unit, in which case they may have to change clinical teams and staff. The manager of the inpatient unit is aware of this and supportive transition work will be carried out with all patients as required.<br><br>All patients will be assessed in order to meet their individual care needs which will take into account any individual issues regarding protected characteristics in accordance with the Trusts Equality and Diversity Policy. It is not expected that service users will experience any detriment as a result of the move and there may be benefits realised for those moving into independent accommodation in tailoring their lifestyle to support personal preferences related to protected characteristics e.g. managing personal relationships, displaying personal memorabilia, etc.<br><br>**Staff:** There should be no impact on staff in relation to protected characteristics. Where staff who transfer to working in the community may have disability issues that require action on the basis of reasonable adjustment for example regarding mobility I the community setting including ability to access patient's accommodation. This will be managed on an individual basis in accordance with the Trusts HR policy on reasonable adjustment.<br><br>**Relatives and carers** |

There should be no impact on carers in relation to protected characteristics. Relatives and carers needs will be taken into account in an individualised manner as part of the clinical assessment of the patient and managed in accordance with the Trust's equality and Diversity policy.

**2. What does the available data and the results of any consultations say about the impact of the proposed changes on the protected characteristics?**

There is no reason from the available data to expect that there will be negative impacts of this change on any service user, staff member or relative or carer as a result of possessing due to any of the protected characteristics, either singly or in combination. There may be unanticipated benefits for some of those with protected characteristics if they move to independent accommodation where they wish to express their identity in a more personalised way that they may have felt able to in a residential or shared treatment setting.

**3. What steps could be taken to minimise any negative impacts that have been identified?**

The service will support people with personalised care and support that includes addressing any Equality and Diversity requirements in their care and support needs on an individualised basis.

| | | |
|---|---|---|
| **4. Could any of the identified negative impacts have a direct (discriminatory) effect?** | **Yes: (How?)** | **No:X** |
| **5. If Y, Can this discrimination be justified?** (I.e. in some cases indirect discrimination can be justified in order to provide a targeted service. E.g. priority flu vaccinations for the over 60's) | **Yes: (How?)** | **No:** |

**Please identify any Action Required, Timescale and Leads**

N/A

**Form completed by:**

**Name:**
Darren Ward/ David Truswell

**Job Title:**
Service Manager/ Project Manager

**Date**: 28.7.16 & amended 08.07.16

This page is left intentionally blank

**Report No.**
**CS17070**

**London Borough of Bromley**

**PART ONE - PUBLIC**

| | |
|---|---|
| **Decision Maker:** | **Health Scrutiny Sub-Committee** |
| **Date:** | **2nd November 2016** |
| **Decision Type:** | Non-Urgent Non-Executive Non-Key |
| **Title:** | **OXLEAS RELOCATION OF LD SERVICES** |
| **Contact Officer:** | Iain Dimond, Service Director, Adult Mental Health and Learning Disability, Oxleas NHS Foundation Trust<br>Lorraine Regan, Clinical Director, Adult Mental Health and Learning Disability, Oxleas NHS Foundation Trust |
| **Ward:** | Borough-wide |

1. Reason for report

1.1 This report outlines the planned move of Bromley Community Learning Disability Team from Yeoman House, Croydon Road, Penge to the Queen Mary's Hospital site, Sidcup.

---

2. **RECOMMENDATIONS**

2.1 Members of the Health Scrutiny Sub-Committee are requested to note the planned move and provide their comments.

Impact on Vulnerable Adults and Children

1. Summary of Impact: Clinicians continue to work with individuals to ensure there is a plan for each service user as to how they will travel to and locate the new service when at the Queen Mary's site. The Trust has a good track record of working with service users who are anxious and will ensure the transition to a new location is done sensitively and takes into account individual circumstances. This will include measures such as clinician-supported visits prior to a formal appointment, activity sessions to provide a positive association with the building and person-centred preparation.

---

Corporate Policy

1. Policy Status: Not Applicable
2. BBB Priority: Not Applicable: Oxleas NHS Foundation Trust service provision.

---

Financial

1. Cost of proposal: Not Applicable
2. Ongoing costs: Not Applicable
3. Budget head/performance centre: N/A
4. Total current budget for this head: £N/A
5. Source of funding: N/A

---

Personnel

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: Not Applicable
2. Call-in: Not Applicable

---

Procurement

1. Summary of Procurement Implications: N/A

---

Customer Impact

1. Estimated number of users/beneficiaries (current and projected): All Bromley servicer users.

---

Ward Councillor Views

1. Have Ward Councillors been asked for comments? Not Applicable
2. Summary of Ward Councillors comments: N/A

## 3. COMMENTARY

Background

3.1 The Bromley Community Learning Disability Team moved to Yeoman House, Penge in February 2013 from its long standing base on the Bassetts House site as this location was scheduled for closure by Bromley Clinical Commissioning Group (BCCG). The Local Authority managed the refurbishment of Yeoman House and the move of the team. Accommodation was provided on the 4th floor of Yeoman house for both the health and social care team. The accommodation included clinical rooms and a physiotherapy gym, as well as offices and meeting rooms.

3.2 Shortly after the move took place, the London Fire Brigade carried out an inspection and deemed the premises unsuitable for use by individuals with physical disabilities due to lack of adequate fire evacuation procedures. An independent fire advisor was commissioned to undertake a piece of work to find a solution to enable the team to continue its work from there. There was also an inspection from a specialist lift advisor to see if the lift in Yeoman House could be upgraded so that it could serve as a fire evacuation lift. Neither of these specialists could find a solution and since that time the team has been unable to offer appointments to service users with physical disabilities (a significant number) at Yeoman house. Instead, the team have had to use a number of existing resources across the Borough to deliver treatment.

3.3 Following this work, late in 2013 the search began for alternative premises for the team to enable its work as a community hub, and considerable time was spent looking at properties supported by the BCCG who linked the team with two potential properties, but unfortunately neither of these was big enough or cost effective.

3.4 In the absence of any other alternative, and to support service users and their families who had become increasingly frustrated at having appointments at different locations, Oxleas' Board agreed that the team could be accommodated in purpose-built accommodation on the Queen Mary's Hospital site in Sidcup, which Oxleas had acquired in October 2013 and are continuing to develop.

3.5 Before a final decision was made, work was undertaken to review where service users lived to determine the likely impact based on geography and the fact that the Queen Mary's site sits on the boundary between Bromley and Bexley. Information was provided by the London Borough of Bromley and Oxleas' informatics department and mapped by postcode. This showed that a higher proportion of service users lived closer to Queen Mary's than the team's current base at Yeoman House.

Queen Mary's Hospital

3.6 The purpose-built department at Queen Mary's has been constructed over the last 12 months and work was completed on 30th September 2016. It provides ground floor clinical space with its own entrance directly from the car park. It has a range of clinical and meeting rooms, including a physiotherapy gym, sensory suite, family consultation suite and a changing places bathroom. All rooms, bathrooms and doors are fully accessible for even the largest wheelchairs and there is a large waiting area with an open reception.

3.7 The office space is on the third floor and is a converted ward. There are a mixture of small and large offices with some break-out spaces. Staff will be expected to follow a hot desking policy which is in place throughout the Trust. The expectation is that service users would always be seen in the ground floor clinical area. If someone was required to attend a meeting on the 3rd floor, it is accessible by lift, which is an approved fire lift.

3.8 Service users and their families have been aware for some time of the plans to move to Queen Mary's as it was first discussed at a service user event in the summer of 2014 at Astley Day Service which was attended by service users and their families. The plans for the clinical space are on display at Yeoman House and there have been a number of discussions with individual service users about their personal circumstances. A group of services users from the Bexley and Bromley Community Learning Disability Teams, who work as an editorial group for Oxleas, has visited the site on two occasions and has made some helpful suggestions on minor improvements such as some changes to the signage which have all been taken on board.

3.9 Clinicians continue to work with individuals to ensure there is a plan for each service user as to how they will travel to and locate the new service when at the site. The Trust know that for some service users there will be challenges, and a questionnaire that was recently completed by a cohort of service users at their scheduled appointments revealed that for some people:

1. Queen Mary's would be further from home
2. The cost of the journey would be higher
3. Service users may be anxious about coming to a different building.

3.10 However, from our conversations with families many of them are keen to have a base where they can drop in to and which is purpose built and fully accessible, and where service users are disadvantaged by the move, the Trust will continue to offer appointments in their own homes or in other Oxleas premises.

3.11 The Trust has a good track record of working with service users who are anxious and will ensure the transition to a new location is done sensitively and takes into account individual circumstances. This will include measures such as clinician-supported visits prior to a formal appointment, activity sessions to provide a positive association with the building and person-centred preparation.

3.12 The Trust is confident that the move represents a very positive opportunity for our Bromley service users to receive care and treatment in accommodation that has been specifically designed with their needs in mind.

| | |
|---|---|
| **Non-Applicable Sections:** | Policy, Financial, Legal, Personnel and Procurement Implications. Impact on vulnerable adults and children. |
| Background Documents: (Access via Contact Officer) | Rehabilitation Summary Briefing<br>2nd November 2016<br>(Report Supplied) |

# Our Healthier South East London Joint Health Overview & Scrutiny Committee

MINUTES of the OPEN section of the Our Healthier South East London Joint Health Overview & Scrutiny Committee held on 17 May 2016 at 6.30 pm at Royal Borough of Greenwich, Town Hall, Wellington Street, Woolwich SE18 6PW

---

**PRESENT:**

Councillor Rebecca Lury (Chairman)
Councillor Judi Ellis (Vice-Chairman)
Councillor Ross Downing
Councillor Jackie Dyer
Councillor Alan Hall
Councillor Robert Hill
Councillor James Hunt
Councillor Averil Lekau
Councillor John Muldoon
Councillor Bill Williams

**OTHER MEMBERS PRESENT:**

| | |
|---|---|
| **OFFICER & PARTNERS SUPPORT** | Greenwich Senior Corporate Development Officer and Committee Officers<br>Dr Angela Bhan, Chief Officer, Bromley Clinical Commissioning Group<br>Mark Easton, Programme Director: Our Healthier South East London Programme |

## 10 APOLOGIES

Apologies were received from Councillor Hannah Gray, Councillor Matthew Morrow, and Councillor John Muldoon for lateness.

## 11 NOTIFICATION OF ANY ITEMS OF BUSINESS WHICH THE CHAIR DEEMS URGENT

There were none.

## 12 DISCLOSURE OF INTERESTS AND DISPENSATIONS

## 13 MINUTES

The following amendments were requested and agreed to the minutes of the meeting held on 26 April 2016:

**RESOLVED**

Item 7 Mental Health – Councillor Jacqui Dyer asked that under the resolved points it be added; clarify visibility within the structure, and that a consultation be brought forward to the next meeting.

Item 8 Sustainability and Transformation Plan – councillor Jacqui Dyer asked that the following amendment be made for detail on specialist mental health commissioning : how many placements and what is the breakdown in terms of 'in area' / 'out of area'

## 14 DISCUSSION OF ANY OTHER OPEN ITEMS AS NOTIFIED AT THE START OF THE MEETING

## 15 URGENT AND EMERGENCY CARE NETWORK

Angela Bhan, Chief Officer Clinical Commissioning Group (CCG) Bromley and responsible officer for South East London urgent and Emergency Care Network presented on the Urgent and Emergency Care Network.

- The Committee requested a copy of the London Urgent and Emergency Care (U&EC) Facilities Specifications.
- The Committee made general point that the information on how existing Emergency and Urgent Care provision meets the Facilities Specifications needs to be clearer and more accessible, especially when it will be presented to members of the public.

In response to questions raised by the Committee the following answers were provided;

- Queen Marys Hospital would not be reduced to 16 hours, this is a minimum level. The full range of diagnostic facilities available needed to be reviewed against the specification. The hospital also provided an out of hours GP service in Bexley.
  Not all Urgent Care Centres (UCCs) are the same.
- This was a first overall view of the facilities. Information for the public and the Ambulance service would be produced and would be more detailed.

- Clarity would be provided regarding slides 5 and 6 for No response / N.A. (grey in key)and limited information available (blue in key). This arose due to some of the questions in the consultation not being clear.

**Action:** Angela Bhan

- The peak time for GP surgeries was mid-afternoon to 10.00pm.
- Facility related to hours and access to diagnostic services etc. The designation was based on the principles shown in the final slide.
- Timeline – The London Quality Standards (LQS) were Londonwide and the Sustainability and Transformation Plan (STP) was a national initiative and the aim is to deliver as soon as possible. At present the south-east was ahead of other areas.
- A detailed analysis was required as there was a need to understand what needed to be done by site. A proposed delivery plan was expected by the end of 2016. Changes would occur as the process went along and a set of actions would be agreed to make this happen. These decisions would be made at a local borough level as they would be part of normal improvement programmes.
- Analysis of the impact on the public would be undertaken separately - Community Based (Primary) Care Workstream.
- Engagement would be undertaken with both Healthwatch and the public, and a task group would provide input for the development of general practice and community based care.
- It was noted that communication must be tangible and presented in a way that people understand.

In response to questions raised by the public the following answers were provided;

- The yellow and terracotta colours used in the key for slides 4,5 and 6 both represented ‘partial’.
- A list of the clinical and facility specification standards would be provided to the Committee.

**Action:** Angela Bhan

- There was an expectation that a medical consultant would be available on site 16 hours per day, at present this was not standard, a consultant may cover from home and 24 hour cover was provided but not on site.
  The chair requested that it be made clear what ‘cover’ meant and what was available, this was agreed.
- Not all of the A&E departments met London Quality Standards (LQS) at this time, however additional work would be undertaken to achieve this and would feed into the timeline.

**Action:** Angela Bhan
(Break A&E data down by borough and centre.)

- Criteria should be provided as to what constitutes a change and what did not. All services have interdependencies and there was a need to be aware of the impact on communities.

**RESOLVED**

Request for a copy of the London Urgent and Emergency Care (U&EC) Facilities Specifications.

Provide a breakdown of A & E data by borough and centre.

The information on how existing Emergency and Urgent Care provision meets the Facilities Specifications needs to be clearer and more accessible, especially when it will be presented to members of the public.

## 16 PLANNED CARE: ELECTIVE ORTHOPAEDIC (ECOS)

Mark Easton, Programme Director Our Healthier South East London presented Planned Care: Elective Orthopaedic Centres (EOCs).

The Committee noted that the Consultation is planned to begin in October 2016 and the draft document will be available for the September 2016 JHOSC meeting and the Consultation document will contain a clear clinical case for the proposed new model and options.

The Committee requested more information on the South West London Elective Orthopaedic Centre (SWLOC) and for a visit to be arranged for JHOSC members.

In response to questions raised by the Committee the following answers were provided;

- If two sites were next to each other, then one would need to be inner and one outer London. Queen Mary's was asked to provide an assessment of their suitability. It was likely that three or four sites would come forward. These would be ranked and a consultation would inform the preferred options.
- The following sites had the capacity to separate elective and non-elective surgeries; Queen Marys, Orpington, Guys and Lewisham.
- Implementation of an organised individual patient transport service, as used in the SWLOC model would be considered. Access for visitors and older patients was also one of the criteria being reviewed.
- A consultation would be undertaken if the Committee considered it is required.
- It was important that the centres were co-located with other services, especially with regard to elderly patients who may need to access them. Orpington was currently upgrading to enable the care of complex cases.

- Hospital contracts would be amended so that patients could be channelled. The Competition Authority would need to be content that reasonable patient choice was still available.
- Briggs Review – It was noted that there was a variation in the cost of implants and that cost was not an indicator of quality. Choice would be harder to govern across institutions. However; volume of supply would be cheaper.

In response to questions and issues raised by the public the following answers were provided;

- A consultation would address points raised regarding a standalone service with no access to other services, which would not allow consultants to discuss the wider implications of cases. If the standalone model was not clinically supported then it would not go ahead.
- The risk of a potential financial crisis, as per the SWLOC model, the impact on feeder hospitals, and the enhanced status quo, would be considered within the consultation.
- Information would be shared with the Planning Care Reference Group and the Evaluation Group also has public representation.
- Use of private companies – They would have to prove that they could provide the necessary facilities.

**RESOLVED**

Consultation is planned to begin in October 2016 and the draft document will be available for the September 2016 JHOSC meeting.

The committee recommended that the consultation document contain a clearer clinical case for the proposed new model and options.

A request was made for more information on the South West London Elective Orthopaedic Centre and for a visit to be arranged for JHOSC members.

**17 PART B - CLOSED BUSINESS**

**18 DISCUSSION OF ANY CLOSED ITEMS AS NOTIFIED AT THE START OF THE MEETING AND ACCEPTED BY THE CHAIR AS URGENT**

**19 EXCLUSION OF PRESS AND PUBLIC**

**CHAIR:**

**DATED:**

**Report No.**
**CSD16142**

**London Borough of Bromley**

**PART ONE - PUBLIC**

| | |
|---|---|
| **Decision Maker:** | **HEALTH SCRUTINY SUB-COMMITTEE** |
| **Date:** | **Wednesday 2nd November 2016** |
| **Decision Type:** | Non-Urgent Non-Executive Non-Key |
| **Title:** | **WORK PROGRAMME 2016/17** |
| **Contact Officer:** | Kerry Nicholls, Democratic Services Officer<br>Tel: 020 8313 4602 E-mail: kerry.nicholls@bromley.gov.uk |
| **Chief Officer:** | Director of Corporate Services |
| **Ward:** | N/A |

1. Reason for report

1.1 The Sub-Committee is requested to consider its work programme for 2016/17.

---

**2. RECOMMENDATION**

**2.1 The Sub-Committee is asked to review its work programme and indicate any issues that it wishes to cover at forthcoming meetings.**

Impact on Vulnerable Adults and Children

1. Summary of Impact: Not Applicable

---

Corporate Policy

1. Policy Status: Existing Policy:
2. BBB Priority: Excellent Council:

---

Financial

1. Cost of proposal: No Cost: Further Details
2. Ongoing costs: Not Applicable:
3. Budget head/performance centre: Democratic Services
4. Total current budget for this head: £335,590
5. Source of funding: 2016/17 revenue budget

---

Personnel

1. Number of staff (current and additional): 8 staff (7.27fte)
2. If from existing staff resources, number of staff hours: N/A

---

Legal

1. Legal Requirement: None:
2. Call-in: Not Applicable: This report does not require an executive decision.

---

Procurement

1. Summary of Procurement Implications: None

---

Customer Impact

1. Estimated number of users/beneficiaries (current and projected): This report is intended primarily for Members of this Sub-Committee to use in planning their on-going work.

---

Ward Councillor Views

1. Have Ward Councillors been asked for comments? Not Applicable
2. Summary of Ward Councillors comments: Not applicable

## 3. COMMENTARY

3.1 The Sub-Committee is asked at each meeting to consider its work programme, review its workload and identify any issues that it wishes to scrutinise. The Sub-Committee's primary role is to undertake external scrutiny of local health services and in approving a work programme the Sub-Committee will need to ensure that priority issues are addressed.

3.2 The three scheduled meeting dates for the 2016/17 Council year as set out in the draft programme of meetings considered by General Purposes and Licensing Committee on 22nd March 2016, are as follows:

Wednesday 8th June 2016

Wednesday, 2nd November 2016

Thursday, 9th March 2017

3.3 The draft work programme is set out in Appendix 1 below.

| | |
|---|---|
| **Non-Applicable Sections:** | Impact on Vulnerable Adults and Children, Policy, Financial, Legal, Personnel and Procurement Implications. |
| Background Documents: (Access via Contact Officer) | Previous work programme reports |

**APPENDIX 1**

## HEALTH SCRUTINY SUB-COMMITTEE WORK PROGRAMME

| |
|---|
| **9th March 2017** |
| PRUH Improvement Plan – Update from King's Foundation NHS Trust (presentation) |
| Winter Resilience (LBB/ CCG) |
| Orpington Wellbeing Centre Update (CCG) |
| Joint Health Scrutiny Committee – Update (Chairman) |
| **June 2017 (date TBC)** |
| Outcome of Evaluation of Key Areas of Provision including Cancer, Maternity and Elective Surgery (CCG) |
| **Not Programmed** |
| Care for Adults with Learning Disabilities |
| Update on Dementia Pathway/Services/Support (Oxleas/MIND/LBB) |
| Better Care Fund Projects Update |