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: 19 September 2018

To: Members of the
HEALTH AND WELLBEING BOARD

Councillor David Jefferys (Chairman)
Councillor Robert Evans (Vice-Chairman)
Councillors Marina Ahmad, Graham Arthur, Yvonne Bear, Mary Cooke, Judi Ellis, Keith Onslow, Colin Smith and Diane Smith

London Borough of Bromley Officers:

Janet Bailey	Director: Children's Social Care
Stephen John	Director: Adult Social Care
Dr Nada Lemic	Director: Public Health

Clinical Commissioning Group:

Dr Angela Bhan	Managing Director: Bromley Clinical Commissioning Group
Harvey Guntrip	Lay Member: Bromley Clinical Commissioning Group
Dr Andrew Parson	Clinical Chairman: Bromley Clinical Commissioning Group

Bromley Safeguarding Adults Board

Lynn Sellwood	Independent Chair: Bromley Safeguarding Adults Board

Bromley Safeguarding Children Board:

Jim Gamble QPM	Independent Chair: Bromley Safeguarding Children Board

Bromley Voluntary Sector:

Colin Maclean	Community Links Bromley
Barbara Wall	Healthwatch Bromley

A meeting of the Health and Wellbeing Board will be held at Bromley Civic Centre on **THURSDAY 27 SEPTEMBER 2018 AT 1.30 PM**

MARK BOWEN
Director of Corporate Services

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

AGENDA

1 APOLOGIES FOR ABSENCE

2 DECLARATIONS OF INTEREST

3 MINUTES OF THE MEETING OF HEALTH AND WELLBEING BOARD HELD ON 19TH JULY 2018 (Pages 1 - 10)

4 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 5.00pm on Friday 21st September 2018.

5 CHILDHOOD OBESITY AND PROMOTING EXERCISE AND HEALTHY WEIGHT TO CHILDREN AND YOUNG PEOPLE (Pages 11 - 16)

6 LOCAL CHILD AND ADOLESCENT MENTAL HEALTH SERVICE (CAMHS) TRANSFORMATION PLAN 2018/19 REFRESH (Pages 17 - 24)

7 JOINT STRATEGY FOR AGEING WELL IN BROMLEY (VERBAL UPDATE)

8 DRAFT HEALTH AND WELLBEING STRATEGY (Pages 25 - 58)

9 UPDATE ON DELAYED TRANSFERS OF CARE PERFORMANCE (Pages 59 - 64)

10 BROMLEY SYSTEM WINTER PLAN (Pages 65 - 148)

11 BETTER CARE FUND AND IMPROVED BETTER CARE FUND 2018/19 Q1 PERFORMANCE REPORT (Pages 149 - 162)

12 INTEGRATED COMMISSIONING BOARD UPDATE (Pages 163 - 170)

13 IMPLEMENTATION OF THE RECOMMENDATIONS OF THE FALLS TASK AND FINISH GROUP (VERBAL UPDATE)

14 UPDATE ON PHLEBOTOMY SERVICES (VERBAL UPDATE)

15 COMMUNICATIONS UPDATE (INCLUDING PARTNERSHIP WORKING WITH MYTIME ACTIVE)

16 WORK PROGRAMME AND MATTERS ARISING (Pages 171 - 180)

17 ANY OTHER BUSINESS

18 DATE OF NEXT MEETING

1.30pm, Wednesday 28th November 2018
1.30pm, Thursday 31st January 2019
1.30pm, Thursday 21st March 2019

HEALTH AND WELLBEING BOARD

Minutes of the meeting held at 1.30 pm on 19 July 2018

Present:

Councillor David Jefferys (Chairman)

Councillors Marina Ahmad, Graham Arthur, Yvonne Bear, Mary Cooke, Judi Ellis, Keith Onslow, Colin Smith and Diane Smith

Dr Nada Lemic, Director: Public Health
Carol Whiting, Head of Service for Safeguarding and Care Planning East
Lynn Sellwood, Independent Chair: Bromley Safeguarding Adults Board
Mark Cheung, Programme Director, Integrated Care Services: Bromley Clinical Commissioning Group
Harvey Guntrip, Lay Member: Bromley Clinical Commissioning Group
Dr Andrew Parson, Clinical Chairman: Bromley Clinical Commissioning Group
Colin Maclean, Community Links Bromley
Barbara Wall, Healthwatch Bromley

Also Present:

Councillor Peter Fortune (Portfolio Holder for Children, Education and Families)

17 APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Robert Evans, Paul Feven and Stephen John.

Apologies for absence were also received from Janet Bailey and Dr Angela Bhan, and Carol Whiting and Mark Cheung attended as their respective substitutes.

18 DECLARATIONS OF INTEREST

Councillor David Jefferys declared that he had recently attended the London Youth Games as a guest of Mytime Active, although this is already listed in the Members' Declaration of Interests. The Chairman drew Members' attention to the success of the Bromley Youth Team in winning the Youth Games 2018, and securing a third successive top team position. He had written on behalf of the Board to congratulate the team, coaches and managers.

19 MINUTES OF THE MEETING OF HEALTH AND WELLBEING BOARD HELD ON 7TH JUNE 2018

RESOLVED that the minutes of the meeting held on 7th June 2018 be agreed.

20 QUESTIONS BY COUNCILLORS AND MEMBERS OF THE PUBLIC ATTENDING THE MEETING

No questions had been received.

21 MYTIME ACTIVE: HEALTH AND WELLBEING INITIATIVES (PRESENTATION)

The Board received a presentation from Matthew Eady, Regional Manager (Bromley and South), Helena Taylor, London Regional Manager: Child Weight Management and Prevention Services, Debra Weekes, Mytime Partnerships Manager and Ann Wilbourn, Primetime Manager, Mytime Active on health and wellbeing initiatives being delivered by Mytime Active.

Mytime Active was a social enterprise that aimed to improve people's wellbeing, regardless of their stage of life. Mytime Active offered a wide range of provision across the Borough including fitness and leisure activities as well as breakfast and after school clubs, and had established a Wellbeing Hub at the Spa Leisure Centre that aimed to support people of all ages and fitness levels to improve their wellbeing through becoming more active, eating healthily, developing a more positive approach to life and socialising with others. Key initiatives included Primetime which was a scheme supporting older people to become more active and participate in social events. A number of programmes were available to children and young people including swimming, soft play and the London Youth Games, and programmes to promote healthy lifestyles were also available to children and young people and their parents. Targeted initiatives available to specific groups of young people included sports and music programmes delivered via MyFuture, Arts Train and Bromley Y, and a free leisure offer and training and apprenticeship programme for children looked after.

The Portfolio Holder for Children, Education and Families was pleased to note the variety of universal and targeted Mytime Active programmes available to children and young people, and emphasised the close working links between the Local Authority and Mytime Active, which included representation on the Local Authority's Corporate Parenting Board.

In response to a question from the Chairman regarding Mytime Active's work in reducing social isolation, the Primetime Manager advised the Board that the Primetime scheme was promoted as widely as possible to encourage more older people to become involved including via the volunteers programme, advertising at community events and presentations to residents' associations and other community groups. A Board Member reported that the Bromley Safeguarding Adults Board had identified older men as being more vulnerable to social isolation and was developing a project to address this vulnerability. The Regional Manager

(Bromley and South) confirmed that Mytime Active undertook a range of work with older men including a nationally recognised programme encouraging older men to participate in golf, and would be pleased to link in with this project. A Board Member announced that as part of Jo Cox's legacy, a £20M fund had been made available to charities and community groups to support groups to understand the impact of their work and share best practice about how to prevent loneliness. Charities would be able to apply for a grant from the Building Connections Fund until the end of December 2020, and this represented an opportunity for Bromley-based charities and community groups to undertake further work to address social isolation in the Borough.

In response to a question from a Member, the Regional Manager (Bromley and South) advised that the Mind, Exercise, Nutrition… Do it! (MEND) obesity prevention and treatment programme for children and young people delivered in schools by Mytime Active took a whole-school approach that involved every child, and that individual children and young people identified as needing additional support were referred to appropriate support services. Mytime Active also undertook workforce training in relation to the Healthy Lifestyles Programmes that was primarily targeted at staff working with children and families but could be expanded to Local Authority staff if appropriate. The Regional Manager (Bromley and South) confirmed that work was underway to identify sustainable funding models for Mytime Active's Healthy Lifestyles Programmes in the longer term, which could include the use of Pupil Premium funding.

Several Members commented that Mytime Active's programmes offered a preventative service that reduced pressures on health and social care services, and asked that the activities offered by Mytime Active be optimally communicated to residents.

Action Point: The Communications Executive to review how the activities of Mytime Active were highlighted to residents and provide an update to the next meeting of Health and Wellbeing Board on 27th September 2018 on the actions taken.

The Chairman led Board Members in thanking Matthew Eady, Helena Taylor, Debra Weekes, and Ann Wilbourn for their excellent presentation which is attached at Appendix A.

RESOLVED that the presentation be noted.

22 FALLS PREVENTION SYSTEM REVIEW: FINAL REPORT AND RECOMMENDATIONS

Report CS18159

The Board considered the final report of the Falls Task and Finish Group.

The Falls Task and Finish Group was convened by the Health and Wellbeing Board to investigate the number and types of falls affecting Bromley's older

population and consider falls prevention work in Bromley, including assessing the level of collaboration across primary, secondary, community and social care providers. The review was chaired by Professor Cameron Swift and a range of work had been undertaken including data analysis to establish falls epidemiology in the Borough and meetings with primary, secondary, community and social care partners. The final report of the Falls Task and Finish Group presented a number of recommendations including improving data management and systems, data sharing to identify a strategy to reduce falls in the Borough, increased case identification and referrals to prevention services, workforce development and collaboration across services. It was proposed that the final report of the Falls Task and Finish Group be presented to the Integrated Commissioning Board and that a Bromley Joint Working Group be established to take forward the recommendations of the review within a specified timescale.

In considering the report, a Member stressed the high number of locums and agency staff within primary care and underlined the importance of ensuring that General Practitioners and healthcare organisations were made aware of the support services available to encourage falls referrals. Another Member noted the value of information sharing between health agencies. Mark Cheung, Programme Director: Integrated Care Services, Bromley Clinical Commissioning Group suggested that the proposals reflected the move towards increasingly integrated service models between key health partners, and that there was a need to remove artificial divides between health and social care services. Another Board Member highlighted that the cohort most vulnerable to falls was often reluctant to engage with services until the point of crisis, and that key messages around falls prevention should be conveyed in different ways, such as via residents' associations or community publications. A number of private companies provided health and social care support to Bromley residents and these companies should also be made aware of falls prevention work in Bromley. Another Member suggested that the built environment of care homes be assessed to minimise the risk of falls by care home residents.

A Board Member recognised the link between falls and loss of confidence and noted that this could lead to increased risk of social isolation. From a safeguarding perspective, domestic abuse could also be a causative factor of falls in some cases and partners should be made aware of this.

Members requested that regular updates be provided to the Health and Wellbeing Board to ensure that the recommendations of the Falls Task and Finish Group were delivered in a timely way. To support this, the Programme Director: Integrated Care Services, Bromley Clinical Commissioning Group agreed to act as Lead Officer for this workstream and an update on the Falls Task and Finish Group would be included as part of the regular update to the Board on the work of the Integrated Commissioning Board.

Action Point: Regular updates to be provided to the Health and Wellbeing Board on the implementation of the recommendations of the Falls Task and Finish Group including written updates to be scheduled for 6 and 12 months.

The Chairman led Members of the Health and Wellbeing Board in thanking

Professor Cameron Swift and Laura Austin-Croft for the excellent work that had been undertaken in driving forward the Falls Task and Finish Group, as well as all the primary, secondary, community and social care partners who had contributed towards the review, and suggested that the report be prepared for academic publication.

RESOLVED that:

1) **The final report of the Falls Task and Finish Group be approved; and,**

2) **The report be presented to the Integrated Commissioning Board, with a proposal that a Bromley Joint Working Group be established to take the recommendations forward within a specified timescale. This would include a prioritisation process to enable identified recommendations to be taken forward over the next 12 months.**

23 CHILDREN'S JOINT STRATEGIC NEEDS ASSESSMENT (PRESENTATION)

Report CSD18160

The Board received a presentation from Dr Jenny Selway, Consultant in Public Health on the draft Children's Joint Strategic Needs Assessment 2018.

The Local Authority and NHS Primary Care Trusts had a statutory requirement to produce a Joint Strategic Needs Assessment which aimed to develop an understanding of the current and future health and wellbeing needs of the population to support the setting of strategic priorities in the short and longer term and to inform local commissioning across health and social care. The Children's Joint Strategic Needs Assessment 2018 explored factors affecting health and wellbeing of children and young people in Bromley and had identified a number of key issues including health, mental health, social and lifestyle issues of parents and carers, a reduction in some protective factors including breastfeeding and immunisation rates, and health, mental health, social and lifestyle issues of children and young people including childhood obesity, substance misuse and mental health and wellbeing issues such as self-harm. It was proposed that the findings of the Children's Joint Strategic Needs Assessment 2018 contribute towards the new Joint Health and Wellbeing Strategy in 2018.

In considering the report, the Chairman was concerned to note the findings in relation to substance misuse. The Consultant in Public Health Medicine confirmed that schools had a number concerns around substance misuse by young people and that work would be undertaken with schools to further explore this issue. The Chairman suggested that the Bromley Youth Council be approached to contribute towards this exploration. Another Member noted that previous work by the Bromley Youth Council had identified a 'disconnect' between young people and the police, and that it was important to support young people to build good relationships with the police. A Board Member commented that in his personal experience as a General Practitioner, young people were often referred to support services before the involvement of primary care services but General Practitioners

should be made aware of emerging health issues for children and young people in the Borough, as well as the full range of support available.

The Chairman noted that the findings of the Children's Joint Strategic Needs Assessment would contribute towards the Draft Health and Wellbeing Strategy that would be considered at the next meeting of Health and Wellbeing Board on 27th September 2018 along with a number of other items relating to the health and wellbeing of children and young people.

The Chairman led Members in thanking Dr Jenny Selway for her presentation which is attached at Appendix B.

RESOLVED that:

1) **The draft Children's Joint Strategic Needs Assessment 2018 be approved; and,**

2) **The findings of the Children's Joint Strategic Needs Assessment 2018 feed into a new Joint Health and Wellbeing Strategy in 2018; in particular the Board highlighted the need for the strategy to address the issues of childhood obesity, adolescent mental health, misuse of drugs and the anxieties over violence.**

24 CHAIRMAN'S UPDATE ON CHILDHOOD OBESITY (VERBAL UPDATE)

The Chairman gave an update on work underway to explore the key issue of childhood obesity. This included a meeting that had been arranged with Mr Ashish Desai, Consultant Paediatric Surgeon, King's College Hospital NHS Foundation Trust in August 2018. Mr Desai would be attending the next meeting of the Health and Wellbeing Board on 27th September 2018 to lead a discussion on childhood obesity.

RESOLVED that the updated be noted.

25 EVALUATION OF THE COMMUNITY ALCOHOL PATHWAY PILOT PROGRAMME

Report CS18161

The Board considered the findings of an evaluation of the Community Alcohol Pathway Pilot Programme and proposals to mainstream the Community Alcohol Pathway.

The Community Alcohol Pathway had been designed to address the increasing prevalence of harmful alcohol consumption in Bromley, improving the low treatment rates for alcohol users and supporting closer working between primary care and the specialist substance misuse treatment service. Delivered by Change Grow Live, the current provider of substance misuse services for adults and young people, the five month Pilot Programme commenced in January 2018 and was

delivered at three General Practitioners Surgeries comprising Broomwood Surgery, Elm House Surgery and Cator Medical Centre. During the course of the pilot, 36 clients had been referred to the Community Alcohol Pathway, with 27 clients completing the assessment process. Of those clients completing the assessment process, 13 had been identified as drinking at harmful and hazardous levels, 11 of which had engaged with treatment with 9 successfully completing treatment and reducing their alcohol consumption to safe drinking levels. 14 clients who had completed the assessment process had been identified as drinking at dependent levels and were referred for structured treatment at the substance misuse service with 11 clients still engaged in treatment via Harm Reduction Groups or Pre-Detox Groups. The Community Alcohol Pathway had been included in the specification for the new contract for the Adult Substance Misuse Service and it was planned to use the findings of the Pilot Programme to inform the mobilisation of the new contract.

The Assistant Director: Public Health underlined the importance of raising public awareness of the harmful effects of substance misuse.

A Board Member noted that delivering the Pathway via General Practitioners Surgeries had reduced the stigma of accessing substance misuse services and that community-based services were often easier to access for service users. The Board Member emphasised the need to ensure better coverage of the scheme across the Borough, and the Assistant Director: Public Health confirmed that work was underway to identify and establish a number of Community Alcohol Pathway hubs across the Borough.

RESOLVED that:

1) **The findings from the evaluation of the Community Alcohol Pathway Pilot Programme be noted; and,**

2) **The Community Alcohol Pathway be supported and promoted amongst partners.**

26 WINTER REVIEW

Report CS18163

Mark Cheung, Programme Director: Integrated Care Services, Bromley Clinical Commissioning Group presented an evaluation of £628k of services commissioned to provide additional capacity and help manage increased seasonal demand during Winter 2017/18.

The Bromley Clinical Commissioning Group had commissioned a range of schemes that enhanced and provided additional capacity for key health services during Winter 2017/18. The commissioned schemes were targeted towards admission avoidance, patient flow and primary care, and included a Community Matron resource, packages of care and emergency placement support and an additional Discharge Coordinator to reduce Delayed Transfers of Care. Investment had also been made in Urgent Care Centres to maximise the efficiency

of primary care services which had been supplemented by an increased number of General Practitioner home visits, with 274 patients visited in their own home as at the end of January 2018. There had been a significant increase in attendance of health services during Winter 2017/18, and although performance had not met national standards it had been higher than in previous years and showed a considerable improvement in responsiveness and recovery rates. Work was underway to identify learning from Winter 2017/18 that could benefit future planning, and this was likely to include earlier planning and mobilisation of schemes and the use of existing service provision to develop an integrated urgent and emergency care system in the community to reduce the need for hospital-based care and support.

In considering the update, the Portfolio Holder for Adult Care and Health Services noted that increased demand for health services did not just impact the Christmas period, which was why many winter services had been designed to run until the end of April each year.

In response to a question from the Chairman, the Programme Director: Integrated Care Services, Bromley Clinical Commissioning Group confirmed that the Bromley Clinical Commissioning Group's response to managing the health impact of the recent heatwave was set out in its Adverse Weather Response Plan. The Bromley Clinical Commissioning Group worked closely with key partners to ensure the right measures were in place to address health issues caused by a sustained period of hot weather. The Director: Public Health reported that the Local Authority had established a system by which messages and advice from Public Health England was provided to all care homes and domiciliary care providers across the Borough.

RESOLVED that the update be noted.

27 BETTER CARE FUND 2017/18 - Q4 PERFORMANCE UPDATE

Report CSD18038

The Board considered an update on the performance of the Better Care Fund 2017/18 up to the end of March 2018, including expenditure and activity levels.

The Better Care Fund was a programme spanning the NHS and the Local Authority which aimed to join up health and care services to support people to manage their own health and wellbeing and live independently in their communities for as long as possible. Developed by the Local Authority and Bromley Clinical Commissioning Group, Bromley's Better Care Fund 2017-19 Local Plan had been endorsed by the Health and Wellbeing Board at its meeting on 7th September 2017 and formally approved by NHS England on 27th October 2017. The Better Care Fund allocation for Bromley for 2017/18 was £22.1M which was being used to fund a number of locally agreed schemes including additional capacity for Reablement Services, the Dementia Universal Support Service, Health Support for Care Homes and Extra Care Housing and Early Intervention and Self-Management schemes to support people to maintain their independence in the community for longer. Schemes providing carer support services and community equipment were also funded and the Local Authority and Bromley

Clinical Commissioning Group would continue to work towards the increasing integration of health and social care.

In considering the report, the Chairman underlined the need to raise public awareness of the positive impact of schemes funded by the Better Care Fund. Revised performance data for Bromley Well for the period of October 2017 to March 2018 that had been included in the report at Paragraph 4.29 would be provided to Board Members following the meeting.

Board Members were advised that future performance updates on the Better Care Fund and Improved Better Care Fund would be presented in a joint report.

RESOLVED that the report be noted.

28 WORK PROGRAMME AND MATTERS ARISING

Report CSD18094

The Board considered its work programme for 2018/19 and matters arising from previous meetings.

A number of items were added to the forward rolling work programme for the meeting of Health and Wellbeing Board on 27th September 2018 as outlined below:

- Bromley Local CAMHS Transformation Plan
- Draft Health and Wellbeing Strategy

A number of existing items on the forward rolling work programme for the Health and Wellbeing Board were also rescheduled.

RESOLVED that the work programme and matters arising from previous meetings be noted.

A NEW THEMES FOR HEALTH AND WELLBEING BOARD WORK PROGRAMME 2018/19 (DISCUSSION ITEM)

The Chairman led Board Members in considering new themes to be added to the Health and Wellbeing Board Work Programme 2018/19.

RESOLVED that the Health and Wellbeing Board Work Programme 2018/19 be updated to reflect Members' comments.

29 ANY OTHER BUSINESS

There was no other business.

30 DATE OF NEXT MEETING

The next meeting of the Health and Wellbeing Board would be held at 1.30pm on Thursday 27th September 2018.

The Meeting ended at 3.50 pm

Chairman

Report No.
CS18178

London Borough of Bromley

Decision Maker:	**HEALTH AND WELLBEING BOARD**
Date:	**27th September 2018**
Title:	**CHILDHOOD OBESITY AND PROMOTING EXERCISE AND HEALTHY WEIGHT TO CHILDREN AND YOUNG PEOPLE**
Contact Officer:	Finola O'Driscoll, Children and Young People Programme Lead Public Health, London Borough of Bromley Tel: 020 8641 7772 E-mail: finola.odriscoll@bromley.gov.uk
Ward:	Borough-wide

1. Summary

1.1 The report sets out the current position on childhood healthy weight and childhood obesity in Bromley and provides a description of current programmes and initiatives designed to support children and families to maintain healthy weight and address the problem of obesity.

2. Reason for Report going to Health and Wellbeing Board

2.1 This report is an update from the original paper that was previously presented to the Health and Wellbeing Board on 8th February 2018. It links to 'Bromley Children and Young Person Joint Strategic Needs Assessment 2018 Section 3: Children and Young People with Emerging Needs'

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

3.1 The Health and Wellbeing Board is requested to note the contents of this report.

Health & Wellbeing Strategy

1. Related priority: Obesity

Financial

1. Cost of proposal: Not Applicable

2. Ongoing costs: Not Applicable

3. Total savings: Not Applicable

4. Budget host organisation: Not Applicable

5. Source of funding: Not Applicable

6. Beneficiary/beneficiaries of any savings: Not Applicable

Supporting Public Health Outcome Indicator(s)

Yes: Further Details

2.02i Breastfeeding – breastfeeding initiation

2.02ii Breastfeeding – breastfeeding prevalence at 6-8 weeks after birth

2.06 Child excess weight in 4-5 and 10-11 year olds - 4-5 year olds

2.06i Child excess weight in 4-5 and 10-11 year olds – 10-11 year olds

---

4. COMMENTARY

4.1 The National Childhood Measurement Programme (NCMP) is recognised internationally as a world-class source of public health intelligence. For over ten years population-level data has been gathered to allow analysis of trends in growth patterns and obesity. Heights and weights of children entering and exiting primary school are measured and used to calculate a Body Mass Index (BMI) centile. The measurement process is overseen by trained healthcare professionals in schools.

4.2 NCMP is mandated for Public Health. All eligible schools in Bromley participate in the programme and every year over 95% of all eligible pupils are weighed and measured at age 4-5 and again at age 10-11.

4.3 The rate of childhood obesity in Bromley is one of the lowest rates in London, however:

- The percentage of children in Bromley schools who are obese doubles from their first year in primary school to their final year
- There is a marked difference in the rates of childhood obesity within Bromley, the prevalence of obesity is higher in deprived wards in the borough

4.4 In Bromley, families of children who are assessed as being outside the healthy weight range are signposted to Change4life on-line NHS resources to support them to make healthy changes to their lifestyles. Severely obese children are offered an appointment with a children's dietitian and can access a drop-in dietetic clinic for some further advice and weight checks.

4.5 Being overweight or obese in childhood has consequences for health in both the short term and the longer term. Once established, obesity is extremely difficult to treat, so prevention and early intervention are very important. Obesity is a major contributory factor in diabetes, heart disease, musculo-skeletal disease, reproductive disorders, respiratory disorders, certain cancers and psychological illness.

4.6 **Breastfeeding**

4.7 Breastfeeding is key to the prevention of childhood obesity. Breastfeeding is important in reducing disease risk later in life, including overweight and obesity in childhood.

- Exclusive breastfeeding (baby only offered breastmilk or water in first 6 months of life) precludes inappropriate feeding practices that could lead to unhealthy weight gain.
- Formula-fed babies have higher protein and energy intake than breast-fed babies, leading to increased body weight during the neonatal period.
- Evidence suggests that higher protein intake and weight gain early in life is positively associated with the development of obesity later in childhood.

4.8 Breastfeeding rates remain relatively low in Bromley. In partnership with health and voluntary sector colleagues, actions to increase the rate of breastfeeding locally include:

- The 0-4 Health Visiting and Family Nurse Partnership Service achieving the Baby-Friendly Initiative status
- Facilitating local breastfeeding support and social groups

4.9 NICE guidance (CG43, 2015) on obesity prevention includes recommendations for local authorities that refer to a holistic approach involving co-ordinated efforts by those who manage, plan and commission services such as transport, sports and leisure and open spaces. Initiatives that support healthy weight for Bromley children and families include:

- Healthy Schools
- Healthy Early Years
- Bromley School Games
- Bromley Road Safety Unit
- The “daily mile”

4.10 **Healthy Schools**

4.11 In Bromley ninety-three schools are currently registered to participate in Healthy Schools London (HSL). HSL is an awards programme that all London schools can choose to participate in to improve children and young people's health and well-being at school level. Bromley schools engage well in this initiative. Bromley school projects include: pupils managing a break time tuck shop selling only healthy snack options; re-designing menus to offer healthier options at a primary school breakfast club; and facilitating physical activities for children outside the school day.

4.12 **Healthy Early Years**

4.13 Healthy Early Years London (HEYL) is a newly launched regional awards scheme which supports and recognises achievements in child health, wellbeing and education in early years settings. One hundred and ten Early Years settings in Bromley have already registered and the Biggin Hill Children and Family Centre are the first setting in Bromley to achieve a Bronze award.

4.14 **Bromley School Games (SGO)**

4.15 Most Bromley schools engage well with SGO programmes and Bromley’s participation in regional competitions is well above the average for London. The majority of primary schools in the borough use their PE and Sport Premium funding to contribute to the co-ordination of an inter-school competition programme. A key priority for SGOs is to encourage inactive children and young people to participate in activities.

4.16 **Bromley’s Road Safety Unit**

4.17 Active travel supports a whole system approach, encouraging everyday physical activities as one of the key ways to maintain healthy weight. The majority of schools in Bromley promote travelling to school by methods other than a car. Schools are supported to become accredited under a national recognition scheme called STARs. Initiatives such as ‘walk on Wednesday’ the ‘Walking Bus’ and ‘Bikeability’ all contribute to an environment where being active is a normalised part of day to day life for families in Bromley.

4.18 **The Daily Mile**

This initiative was founded by a head teacher in a Scottish primary school. It is a simple and free way to get children out of their classroom for fifteen minutes every day to run or jog at their own pace. A recent evaluation of the ‘Daily Mile’ found beneficial effects upon physical activity levels and body composition. As part of the Council’s commitment to supporting vulnerable families, there is keen interest in promoting this initiative to Bromley schools. A small number of schools are doing the daily mile and more schools have expressed an interest in starting this initiative.

5. IMPACT ON VULNERABLE PEOPLE AND CHILDREN

5.1 Childhood obesity is a significant health inequalities issue. The prevalence of obesity is higher in deprived wards in the borough. National data shows that child obesity prevalence rises as household income falls and that children from black and minority ethnic families are also more likely than children from white families to be overweight or obese. This inequality gap is increasing (Childhood obesity: a plan for action, 2018).

5.2 In 2016/17 NCMP data shows that obesity prevalence for children living in the most deprived areas is more than double that of those living in the least deprived areas. This difference is seen for both Reception and Year 6. The difference in obesity prevalence between the most and least deprived areas has increased over time. It has increased more for boys than girls in Year 6.

5.3 The national "Childhood obesity: a plan for action" sets out a national ambition to halve childhood obesity and significantly reduce the gap in obesity between children from the most and least deprived areas by 2030.

6. COMMENT FROM THE DIRECTOR OF AUTHOR ORGANISATION

6.1 Public Health is committed to continuing to support a whole system approach as being the best way forward with prevention at the centre of this approach. Active engagement in the London Obesity Network will continue and implementation of best practice initiatives based on 'what works' in different communities will be considered.

Non-Applicable Sections:	Financial and Legal Implications, Implications for other Governance Arrangements, Boards and Partnership Arrangements
Background Documents: (Access via Contact Officer)	Bromley Children and Young Person Joint Strategic Needs Assessment (2018) National child measurement programme: briefing for elected members (2013) Childhood obesity: a plan for action (HM Government 2018)

This page is left intentionally blank

Report No.
CS18179

London Borough of Bromley

Decision Maker:	**HEALTH AND WELLBEING BOARD**
Date:	**27th September 2018**
Title:	**LOCAL CHILD AND ADOLESCENT MENTAL HEALTH SERVICE (CAMHS) TRANSFORMATION PLAN : 2018/19 REFRESH**
Contact Officer:	Nazmin Mansuria, Senior Commissioning Manager NHS Bromley CCG Tel: 0203 930 0221 E-mail: Nazmin.Mansuria@nhs.net
Ward:	Borough-wide

1. Summary

1.1 There is a requirement for the Bromley Clinical Commissioning Group (BCCG) and its partners to complete a Local CAMHS Transformation Plan refresh for 2018/19 for submission for assurance purposes to NHS England. This refresh must be endorsed by Bromley's Health and Wellbeing Board prior to submission to NHS England.

2. Reason for Report going to Health and Wellbeing Board

2.1 The allocation of additional resources for the delivery of the CAMHs Transformation Plan in 2018/2019 are dependent on the Health and Wellbeing Board's endorsement of this year's refreshed Plan; however as the submission date to NHS England for the Local CAMHS Transformation Plan 2018/19 is on 31st October 2018, the Executive Summary is submitted for review and comment. (appendix 1). The draft plan will be circulated before submission. The final plan will be approved through a Chair's action on the provison that the Transformation Plan 2018 has been considered in full by the Health and Wellbeing Board members.

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

3.1 The Health and Wellbeing Board is requested to review and comment on the Executive Summary and later endorse the Transformation Plan which will be circulated before the NHSE submission date.

Health & Wellbeing Strategy

1. Related priority: Anxiety and Depression Children with Mental and Emotional Health Problems

---

Financial

1. Cost of proposal: Not Applicable:

2. Ongoing costs: Not Applicable:

3. Total savings: Not Applicable:

4. Budget host organisation: Bromley Clinical Commissioning Group

5. Source of funding: NHS England

6. Beneficiary/beneficiaries of any savings: Not Applicable

Supporting Public Health Outcome Indicator(s)

Yes

---

4. COMMENTARY

4.1 There is a requirement for the Bromley Clinical Commissioning Group (BCCG) and its partners to complete a Local CAMHS Transformation Plan refresh for 2018/19 for submission for assurance purposes to NHS England. This refresh must be endorsed by Bromley's Health and Wellbeing Board prior to submission to NHS England.

4.2 Health and Wellbeing Board members are asked to consider and comment upon the Plan Refresh in order to comply with this assurance process.

4.3 The CAMHS Transformation Plans refresh must be completed and submitted to NHS England by 31st October 2018. This refreshed Plan for Bromley proposes a continuation of the key transformation aims and vision as set out in the initial Local CAMHS Transformation Plan [2015] and confirmed in the subsequent Plan refresh [October 2017]. There are no major changes to the vision or the road map to transformation in the 2018 plan which continues to build on the focus on:

a) Increasing capacity across the system to cope with increasing demand;
b) Improving accessibility to services;
c) Improving the quality of the service offer across early intervention and specialist community CAMHS; and,
d) A commitment to co-producing the future system and referral and care pathway design.

4.4 The initial Local CAMHS Transformation Plans [2015/2016] were jointly developed with the local authority and with delivery and sector partners. The subsequently published refreshed Local Transformation Plans [2017, 2018] set out the change and improvements that have been achieved to date in transforming local emotional wellbeing and mental health services. The 2018 refreshed Plans also incorporate further evidence of the impact that the allocations of Transformation Plan investments have had on the system to date, providing oversight on improved outcomes and learning.

4.5 This year refresh plan is a continuation from previous and new National strategies includes the following:

a) Outcomes and achievements from last year's investment. Bromley has exceeded the National target of 30% for CYP access in mental health services.

b) Progression on co production and co design of the new CAMHS system, this includes risk and mitigation. Over the past 12 months, a robust framework has been developed from which to start reshaping the CAMHS system. The project is now moving beyond co-production to the co-design phase.

c) Improvements and work streams at STP (Sustainability & Transformation Partnership): there are a number of wider aligned regional (STP) and national schemes and drivers that have an impact on the local Plans. These are reflected in the most recent refresh and include commitments to improve crisis care and deliver care closer to home and to seek closer working across the STP footprint.

d) Bromley CCG is working with South East London (SEL) CCGs, Local Authorities and NHS England Specialised Commissioning as part of the SEL Transforming Care Partnership (TCP). The vision of the Partnership is for people with learning disabilities and or autism to achieve equality of life chances, live as independently as possible and to have the right support from mainstream health and care services.

e) A strong focus on schools, following the Government's response to this Green Paper in July 2018 NHS England are inviting a limited number of CCGs to form the first wave of

'trailblazer' areas. The trailblazers will be the first to implement and test the delivery model for the Mental Health Support Teams (MHSTs), and in some areas the 4-week waiting time for access. Additional support and resources are available to facilitate this and learning from the trailblazers will inform future roll-out of the proposals. Bromley has been pre-selected to submit EOI. Bromley has exceeded its access targets for children and young people's mental health across the STP (Sustainable Transforming Partnership) therefore, placing it in a prime position to submit the EOI.

Trailblazer Model includes:

- To incentivise and support all schools to identify and train a Designated Senior Lead for Mental Health with a new offer of training to help leads and staff to deliver whole school approaches to promoting better mental health;

- To fund new Mental Health Support Teams (MHSTs), supervised by NHS CYP mental health staff, to provide specific extra capacity for early intervention and ongoing help within a school and college setting; and as the new Support Teams are rolled out, NHS England will trial a four week waiting time for access to specialist NHS CYP mental health service.

4.6 Our local strategic ambitions continue from previous years:

- To co-design and co-produce children and young people's emotional wellbeing and mental health referral and care pathways to respond to need.
- To exceed the national target of 35% of those with mental health needs to be accessing, or having accessed, appropriate evidence based treatment and support at the right time and in the right place.
- To improve the quality of outcomes that children and young people can expect as a result of their contact with services
- To ensure that waiting times (referral to treatment) are kept within clinically appropriate time frames (four weeks)
- That communities are supported to keep well
- To collaborate with schools, the voluntary sector and health providers to prevent need
- That individual treatment gains and the step change in services are sustainable
- That fewer children present to services in crisis and fewer children and young people are admitted to inpatient units
- That more children have their needs met closer to home
- That services are co-designed and co-produced with children, young people, communities, faith groups and professionals
- To develop a workforce capable of delivering the new services

5. IMPACT ON VULNERABLE PEOPLE AND CHILDREN

5.1 Children and young peoples emotional wellbeing and mental health affects all vulnerable groups across health, socialcare and education system.

Non-Applicable Sections:	Financial and Legal Implications, Implications for other Governance Arrangements, Boards and Partnership Arrangements, including any Policy and Financial Changes required to Process the Item, Comment from the Director of Author Organisation.
Background Documents: (Access via Contact Officer)	N/A

EXECUTIVE SUMMARY

Introduction & Executive Summary

In presenting the refreshed CAMHS Transformation Plan 2018, NHS Bromley CCG would like to acknowledge all the contributions of ideas, innovation and hard work local, regional and national partners and colleagues have made to making change a reality for children and young people on the ground over the course of this last year. Partners have really "grasped the nettle" and responded positively to the challenges of delivering transformation.

The refreshed CAMHS Transformation Plan [2018] provides an update on the progress made against the priorities and ambitions set out in the first Local Transformation Plan [October 2015].

The CAMHS system both nationally and locally is under intense pressure with increasing number of children and young people accessing the system and complexity of need rising. It is only through collaborative working with all stakeholders that the challenge to deliver system change can be achieved. This requires collaboration, innovation and challenging attitudes, mindsets and behaviours to reform Bromley CAMHS provision, ensuring that views and voices of children and young people are at the centre of the reforms and that the care pathways are significantly improved.

ACHIEVEMENTS

Bromley's Achievements 2017-2018

a) The national target for access to assessment and treatment for CYP mental health is 30%. Bromley has exceeded this target, achieving a figure of 30.8% . This is an exceptional outcome and places Bromley ahead of many other local areas. This has been achieved through embedding joint commissioning arrangements between CCG and the Local authority which has enabled resources to be deployed efficiently and effectively.

b) At the start of the transformation process Bromley had a fragmented CAMHS system with strong focus on specialist services. Strategic leaders have built, and are continuing to build strong relationships to successfully deliver a joint CAMH's system, with single point of access and specialist CAMHs services working towards mitigating the current challenges and pressures.

c) Bromley Co production and co design journey is now embedded in our transformation process. Approximately 2300 children, young people and parents have been involved in the insight phase of the project to test and prioritise outcomes and that mattered to them Over the past 12 months, a robust framework, Dynamic of well being, has been developed from which to start reshaping the CAMHS system. The project is now moving beyond co-production to the co-design phase which will inform commissioning optional appraisal.

d) Transformation funding has continued to support key service developments, including:

- School responder and consultation service providing a crisis response service, enabling school staff to manage and support specific issues for individual children & young people within schools in a timely way

- Mental health first aid Training: accredited training to 'Train the Trainer' facilitators across the system so that front line staff from all agencies who work with children and young people can be trained in the basic identification of emotional wellbeing.
- Increased capacity for Children's wellbeing practitioners at the single point of access. (Children's Wellbeing Practitioners) are an essential part of the government's future investment in mental health and this plan is aligned with the national vision to (i) provide earlier intervention and (ii) to develop a sustainable workforce for the future)
- Embedding CYP IAPT (improving Access to psychological treatments) this is a quality initiative to deliver an evidence based intervention
- Eating disorders: establishing a telephone self- referral and GP referral consultation for eating disorders

e) Health and Justice **–**An extensive study was commissioned to review health needs and health provision for children and young people in the youth justice system. The outcomes produced nine recommendations to improve the service provision which will be prioritised in 2018 -2019.

STP Achievements 2017/18

In 2017, the three NHS mental health trusts in South London (Oxleas, SLaM, South West London and St George's) formed the South London Partnership (SLP). In October 2017, the CAMHS New Care Model took over from NHSE the responsibility for commissioning and delivering in Tier 4 CAMHS services

The aim of the New Care Model is to provide young people with complex, severe and acute needs, with high quality specialist care and evidence based interventions within their communities which will help them to recover and in so doing, to minimise disruption to their lives by reducing the need for inpatient care. It is anticipated that by reducing admissions and length of stay, investments can be made in community services in order to improve young people's access to specialist care and in so doing, improve their outcomes.

The SLP has established an Integrated Bed Management Hub which has delivered rapid improvements for young people admitted to CAMHS inpatient settings. For Bromley this means that more young people are now accessing inpatient beds in South London rather than being placed at some considerable distance from home. In 2016/17 (pre New Care Model) 43% of inpatient admissions of Bromley young people were out of area. This meant that they were likely to stay longer, their families found it harder to visit and education, family life and friendships were disrupted. During 2017/18 this reduced to 29% and in 2018/19 (YTD) there has been a further reduction to 10%.

Transforming Care

Bromley CCG is working with South East London (SEL) CCGs, Local Authorities and NHS England Specialised Commissioning as part of the SEL Transforming Care Partnership (TCP). The vision of the Partnership is for people with learning disabilities and/ or autism to achieve equality of life chances, live as independently as possible and to have the right support from mainstream health and care services.

RISK AND CHALLENGES FOR 2018 – 2019 and BEYOND

Transforming and implementing the new emotional wellbeing and mental health system (0-25)

The scale of transforming Bromley's CAMHS system is highly ambitious and subsequently will present some significant challenges. This will require detailed planning and whole scale commitment across the CYP landscape. This will entail:

- Transition from current to new system – parallel planning to ensure no child is lost.
- Realistic timescales for Mobilisation
- Move away from traditional tier based model
- Behaviours/ workforce / culture
- Outcomes based commissioning
- Procurement strategy options to be investigated.
- Involving young people on a equal platform
- Maximising using community provision – voluntary
- Increasing demand static resources
- Need to develop 0-25 system, disaggregating funding from adult's contracts
- Greater emphasis on early intervention/ prevention whilst managing the rise in crisis presentation at specialist service.

The 2018 JSNA has highlighted significant needs rising in Bromley population for example gangs, violence, knife crime, drug and alcohol. These multiple needs subsequently affect the rising in CYP mental health in Bromley. These issues have not been previously identified as areas where potential significant resources will be required to meet emerging needs, nor has consideration been given to fully equip the workforce in responding to these challenges. There is appetite for Bromley to use the STP a vehicle to gather evidence for an appropriate response to transform services.

There is an increase in numbers of CYP with mental health needs co morbid with other needs for example those with Autistic spectrum disorders with severer mental health needs.

The challenge remains in meeting national CYP access targets of 35%

There is focus in reducing A and E presentations and mitigating waiting times for specialist CAMHS provision. In 2017 -2018 there has been 297 children and young people presented to A&E in Bromley with a mental health crisis. 2018/19 data shows a projected annual increase of 35% and a projected 5 year increase of 212%. Around 50% of these young people are not known to Specialist CAMHS.

Mobilising Trailblazer MHST (Mental health support teams) and 4 week waiting pilot innovation if successful. The timescales for mobilising the scheme are expected to deliver simultaneously with the new emotional well- being and mental health system.

AMBITION FOR THE FUTURE

Implementation of the new co- produced and co designed emotional wellbeing and mental health system. Bromley will focus on schools for CYP mental health.

Bromley has been pre -selected for trailblazer funding bids. If successful the innovation would enhance the current offer, enhance resources, enable greater voluntary sector involvement and expertise in service delivery and build on the existing workforce expertise in schools.
Bromley is ambitious to get it "right" and has made solid steps in the right direction over the course of the last two years. Emergent data confirms our expectations that transformation in community based approaches and referral and care pathways is possible and is starting to have a positive impact at critical points in the current pathways. But there is still much to do.

As such this refreshed Plan should be read with reference to the CAMHs Transformation Plan published in October 2017

http://www.bromleyccg.nhs.uk/news/new-tranformation-plan-to-support-support-the-emotional-wellbeing-and-mental-health-of-children-and-young-people-in-bromley/17622,"

https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

https://www.gov.uk/government/consultations/transforming-children-and-young-peoples-mental-health-provision-a-green-paper

Report No.
CS18180

London Borough of Bromley

Decision Maker:	**HEALTH AND WELLBEING BOARD**
Date:	**27th September 2018**
Title:	**DRAFT HEALTH AND WELLBEING STRATEGY**
Contact Officer:	Dr Nada Lemic, Director of Public Health Tel: 020 8313 4220 E-mail: Nada.Lemic@bromley.gov.uk
Ward:	Borough-wide

1. Summary

1.1 A review of the methodology for the LBB's Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JHWS) has been conducted resulting in proposed new methodologies for both.

1.2 New priorities for the JHWS were agreed in the previous meetings of the HWB, Thursday 7th June 2018 and Thursday 19th July 2018.

1.3 A refresh of the JHWS now includes the priorities agreed in the previous HWB meetings as described above.

2. Reason for Report going to Health and Wellbeing Board

2.1 New priorities for the refresh of the JHWS were agreed during the last two HWB meetings (Thursday 7th June 2018 and Thursday 19th July 2018). A draft JHWS has since been developed to include the priorities chosen by the HWB and this paper presents this draft document for consideration by the HWB.

2.2 The Draft JHWS (Appendix 1) provides a structure for the new document and outlines the proposed process for developing the action plans for each of the 10 priorities identified and a process for reporting progress on these action plans to future HWB meetings.

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

3.1 The Health and Wellbeing Board is asked to consider the outlined Draft Joint Health and Wellbeing Strategy document at Appendix 1, and;

1) Agree upon the proposed structure for the JHWS; and,

2) Agree the process outlined for the next stage of the strategy – developing the action plans and the reporting process.

Health & Wellbeing Strategy

The Health & Wellbeing Strategy outlines the priorities (based on the Joint Strategic Needs Assessment) agreed by the Health & Wellbeing Board together with the aims and expected outcomes.

Financial

1. Cost of proposal: No Cost

2. Ongoing costs: No Cost

3. Total savings: Not Applicable

4. Budget host organisation: Not Applicable

5. Source of funding: Not Applicable

6. Beneficiary/beneficiaries of any savings: Not Applicable

Supporting Public Health Outcome Indicator(s)

The process for identifying priorities has been informed by reviewing data from the 2017 JSNA and the online Public Health England resource, Public Health Outcomes Framework.

---

4. COMMENTARY

4.1 Detailed report appended at Appendix 1.

5. IMPACT ON VULNERABLE PEOPLE AND CHILDREN

5.1 Populations affected by the proposed priorities for inclusion in the new JHWS include; the homeless, those with learning disabilities, vulnerable children and young people and those with dementia.

6. LEGAL IMPLICATIONS

6.1 The production of a JHWS has been a statutory requirement of upper tier local authorities and partners since the Health and Social Care Act (2012).

Non-Applicable Sections:	Financial Implications, Implications for Other Governance Arrangements, Boards and Partnership Arrangements, including any Policy and Financial Changes, required to Process the Item, and Comment from the Director of Public Health
Background Documents: (Access via Contact Officer)	Not Applicable

BROMLEY HEALTH AND WELLBEING STRATEGY

2018 – 2022

DRAFT

FOREWORD

On behalf of the Bromley Health and Wellbeing Board I am delighted to present this second Joint Health and Wellbeing Strategy for the Borough, which sets out our local priorities for improving health and wellbeing over the next five years.

Located in South East London, Bromley is the largest London borough in the city. Although Bromley is a relatively prosperous area, the communities within Bromley differ substantially. Although health and wellbeing in Bromley is generally considered to be good there are still areas that could be improved.

Our vision in this second strategy is for the people of Bromley to live an independent, healthy and happy life for longer. In order to achieve this we must come together as a Health and Wellbeing Board to ensure that we make the best use of our collective resources. We will encourage and expect all organisations to use the Joint Health and Wellbeing Strategy when considering actions to improve health and wellbeing and when making decisions about spending money and planning services over the next five years.

This strategy is important. It is a shared agreement between each partner organisation in the Health and Wellbeing Board with, and for, people of all ages living and working in Bromley. It is about what we can and want to change, helping those who commission or provide health and social care, communities and individuals to focus their efforts over the next five years.

CONTENTS

INTRODUCTION

This strategy aims to improve and protect the health and wellbeing of all who live and work in the borough, and sustain Bromley as a healthy place to live, work or visit. We aim to tackle gaps in health inequalities and achieve real and measurable improvements in the health and wellbeing of residents. Our vision is for a healthier Bromley, where everyone is able to benefit from improvements in health and wellbeing.

This strategy has been jointly developed by Public Health Consultants, local authority officers, Clinical Commissioners and GP advisors, NHS representatives, local health and voluntary organisations. The strategy details how the Bromley Health and Wellbeing Board intend to work with cross-sector partners, including local residents, voluntary organisations and community groups, to reduce health inequalities and improve the health and wellbeing outcomes of our local communities and workforces.

What is the Health and Wellbeing Strategy?

It is a statutory document aiming to respond to the health, social care and wellbeing issues in a strategic manner in accordance with the Health and Social Care Act 2012. It brings together those areas which impact on health and wellbeing into a single co-ordinated framework. The strategy will guide the various agencies in Bromley as they tackle the major public health and wellbeing challenges to improve the health of the population and reduce health inequalities. It sets out the commitment to help individuals, families and communities make a positive choice to lead a healthier lifestyle, whilst also doing all we can to address the crucial wider determinants of health. It will identify and bring together a number of overarching priorities for action. From these, more detailed plans will be developed and delivered.

WHAT'S HAPPENED SINCE THE LAST STRATEGY?

The Bromley Health and Wellbeing Board's (HWB) first ever strategy outlined the priorities for improving health and wellbeing of people living in Bromley.

The priorities were identified by considering the burden, numbers of people affected, and whether the problem is improving or worsening over time. The priorities for 2012-15 were agreed as:

- Diabetes
- Obesity
- Hypertension
- Anxiety and Depression
- Dementia
- Support for Carers
- Children with Mental & Emotional Health Problem
- Children Referred to Social Care
- Children with Complex Needs and Disabilities

In 2013 they were then refined to those areas that were considered highest priority:

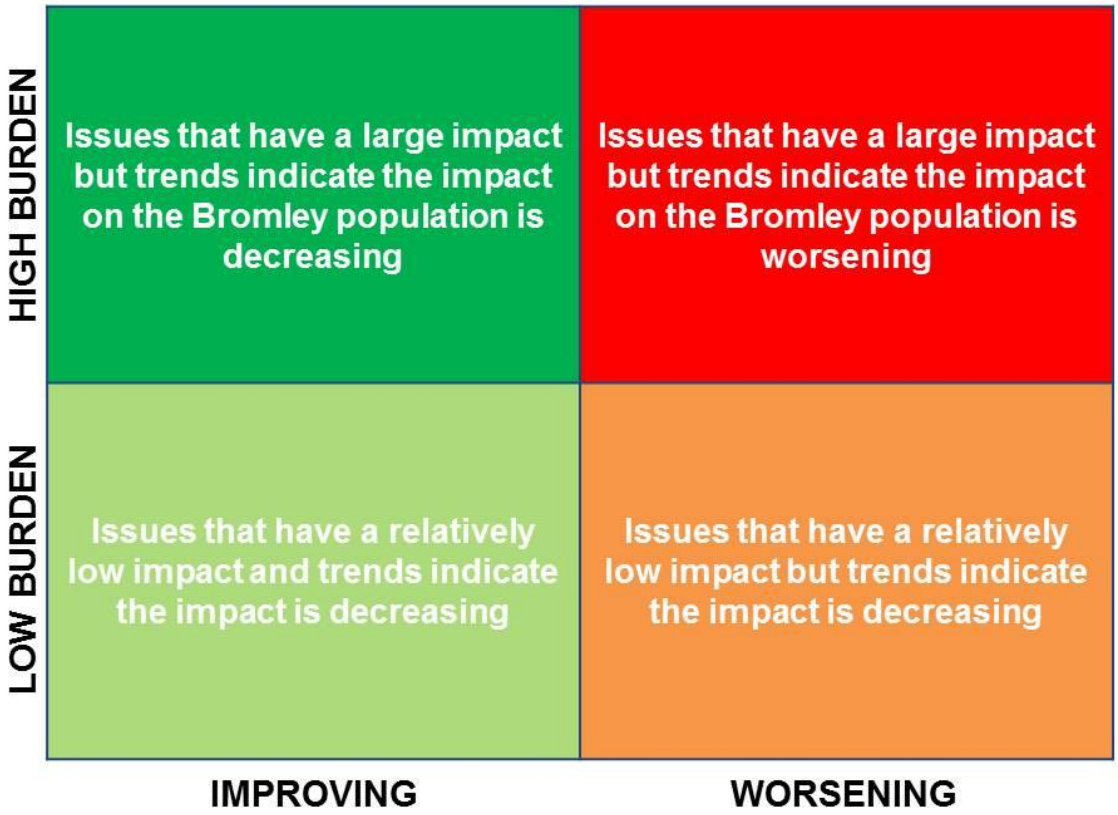
- Diabetes
- Obesity
- Dementia
- Children with Mental & Emotional Health Problems.

In February 2018 the Bromley Health and Wellbeing Board supported the proposal for a comprehensive evaluation of the process of production of the JSNA and of the report itself. It also supported a concurrent review of the methodology used to translate the JSNA findings into priorities for the local Health and Wellbeing strategy.

Methodological approach to the development of this strategy

An evidence-based methodology has been devised to identify potential priority issues for the new Bromley Joint Health and Wellbeing Strategy (JHWS). This has been devised by adapting the previous methodology used to identify priorities for the 2012-15 strategy which in itself was based on an original methodology devised by Hiten Dodhia, Consultant in Public Health for Lambeth.

This methodology is based around the production of a matrix that classifies health and wellbeing issues according to their potential impact on the Bromley population (defined by the prevalence or incidence of disease or mortality) and the recent direction of trends (improving or worsening).



Two sources of evidence have been used to identify potential health and wellbeing issues affecting the Bromley population and assess their relative position within this matrix:

I. Bromley Joint Strategic Needs Assessment 2017(JSNA) [www.bromley.gov.uk/JSNA]
II. The Public Health England Public Health Outcomes Framework (PHOF) [https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/0]

The information on disease morbidity and mortality within the Disease Burden chapter of the JSNA 2017 was used to identify diseases for which the prevalence or incidence was increasing in the Bromley population or mortality rates were rising.

The PHOF for Bromley was reviewed to identify issues that impact on health and wellbeing where the incidence or prevalence in Bromley was higher than the national average and/or the trend indicated the impact on the Bromley population was worsening.

The Life Course Approach to Health and Wellbeing

Members of the Health and Wellbeing Board represent agencies working with all people at all times of their life, from cradle to grave.

Therefore, we have agreed to adopt a 'life-course approach' in our work. As a person travels through different stages in their lives they encounter numerous events and opportunities. These can encourage healthy or unhealthy behaviours which affect a person's overall wellbeing.

The life course approach seeks to prevent and control diseases by identifying critical stages in life from preconception through pregnancy, infancy, childhood, adolescence, adulthood and old age, where interventions will be most effective. A life course approach investigates the long-term effects of physical and social exposures experienced during these aforementioned critical life stages on health and disease risk. It also examines the pathways (biological, behavioural and psychosocial) influencing the development of chronic diseases and operating across an individual's life course or across generations.

The life course approach to health offers a strategic model that can be used to best plan public health interventions that relate to the priorities agreed within the Joint Health and Wellbeing Strategy (JHWS). Interventions planned using a life course approach will be timely, effective and provide lasting benefits.

Our vision:

"Live an independent, healthy and happy life for longer"

PRIORITY 1 – CANCER

WHY IS IT IMPORTANT

- In Bromley cancer rates are rising with nearly 1,600 new cancer registrations annually.
- Cancer is Bromley's number one killer (3,817 deaths)
- It has overtaken cardiovascular disease as the major cause of death in the population
- Survival rates are increasing
- However, many cancers are still detected late

WHAT WE PLAN TO DO

We will work in partnership to produce an action plan which will address the following areas:

- Supporting people in their understanding of cancer, and enabling people to make healthy lifestyle choices
- Increasing awareness of early cancer symptoms and screening programmes to improve early diagnosis
- Understand and overcome the barriers which stop people from taking part in screening
- Targeting areas with high levels of deprivation and where smoking and alcohol use are known to be higher

HOW WE WILL MEASURE SUCCESS

The appropriate partners will decide on a set of outcomes for the action plan and will monitor the progress towards these. A progress update will need to go to the Health and Wellbeing Board twice a year.

PRIORITY 2 – OBESITY

WHY IS IT IMPORTANT

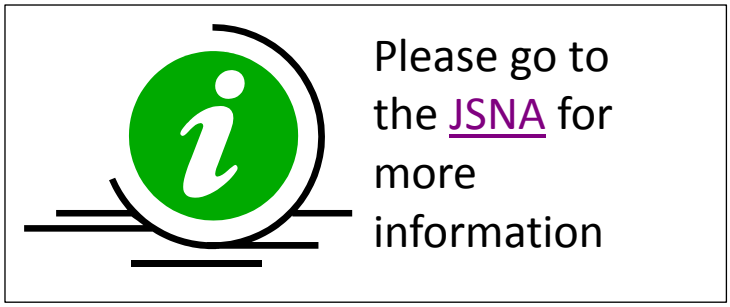
- 57.2% of adults in Bromley are classified as overweight or obese
- Obesity is the main risk factor for the development of type 2 diabetes, with obese adults being five times more likely to develop the condition compared to adults of a healthy weight
- Obesity in children is a significant concern in terms of their health and well-being
- In Reception Year and Year 6 in Bromley primary schools, there are 145 children known to be severely obese as well as 860 obese children
- There are marked differences in rates of obesity within Bromley, with children in the north east and north west of the borough and Mottingham having the highest rates of obesity

WHAT WE PLAN TO DO

We will work in partnership to produce an action plan to develop initiatives and interventions to reduce the overweight and obesity in Bromley.

HOW WE WILL MEASURE SUCCESS

The appropriate partners will decide on a set of outcomes for the action plan and will monitor the progress towards these. A progress update will need to go to the Health and Wellbeing Board twice a year.



PRIORITY 3 – DIABETES

WHY IS IT IMPORTANT

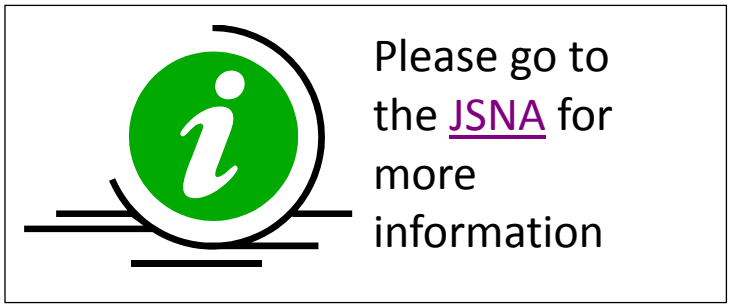
- Over 15,000 people in Bromley are currently diagnosed with diabetes
- A further 30,000 people are estimated to be at risk of developing diabetes
- The number of people with diabetes in Bromley continues to rise and presents a growing challenge for individuals and services.

WHAT WE PLAN TO DO

We will work in partnership to produce an action plan to address the issue of significant increase in incidence and prevalence of diabetes in Bromley.

HOW WE WILL MEASURE SUCCESS

The appropriate partners will decide on a set of outcomes for the action plan and will monitor the progress towards these. A progress update will need to go to the Health and Wellbeing Board twice a year.



PRIORITY 4 – DEMENTIA

WHY IS IT IMPORTANT

- Around 4,380 people aged over 65 in Bromley are living with dementia
- This figure is predicted to rise to 6,034 by 2030
- Overall analysis indicates that the older population (65+) contributes significantly to the dementia prevalence in Bromley
- However, Bromley has significantly higher rates of young-onset dementia compared to London and England

WHAT WE PLAN TO DO

We will work in partnership to produce an action plan which will address the following areas:

- Significantly improving awareness and understanding of dementia so people have the information they need to reduce the risk of developing dementia as well as to live well with dementia
- Ensure people with dementia have equal access to the health and wellbeing support which is available to everyone

HOW WE WILL MEASURE SUCCESS

The appropriate partners will decide on a set of outcomes for the action plan and will monitor the progress towards these. A progress update will need to go to the Health and Wellbeing Board twice a year.

Please go to the JSNA for more information

PRIORITY 5 – SUICIDE PREVENTION

WHY IS IT IMPORTANT

- 20 people die in Bromley every year from Suicide
- Suicides are more prevalent in men, up to 3 times the rate in females
- Hanging, Strangulation, Suffocation and poisoning are the common methods of suicide in Bromley
- Bromley ranks 16th out of 33 London Boroughs on suicide rates
- Bromley has the 5th highest rates of self harm in the region

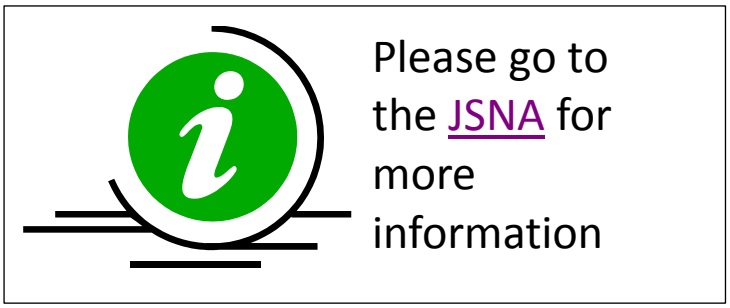
WHAT WE PLAN TO DO

Over the next five years we will:

- Support the Suicide Prevention Strategy Steering Group to develop and deliver a Suicide Prevention Action Plan for Bromley to support delivery of the Bromley Suicide Prevention Strategy

HOW WE WILL MEASURE SUCCESS

The steering group will decide on a set of outcomes as part of the action plan and monitor these within their steering group meetings. A progress update will need to go to the Health and Wellbeing Board twice a year.



PRIORITY 6 – STATUTORY HOMELESSNESS

WHY IS IT IMPORTANT

- The number of households in temporary accommodation has risen significantly in the past seven years. At the end of April 2018 there were1563 households in temporary accommodation placed by Bromley Council. This represents an increase of over 6% from the same period last year
- 62% of placements in temporary accommodation are currently outside the borough
- Challenges around the discharge of duty have caused a slowing in the number of households moving on from temporary accommodation meaning that the net inflow into accommodation is more than those leaving
- 78% of households in TA are families (pregnant or with at least one dependent child). The most common household composition in TA is single-parent households (61%). 17% of households in TA are couples with dependent children and 19% are single-person households

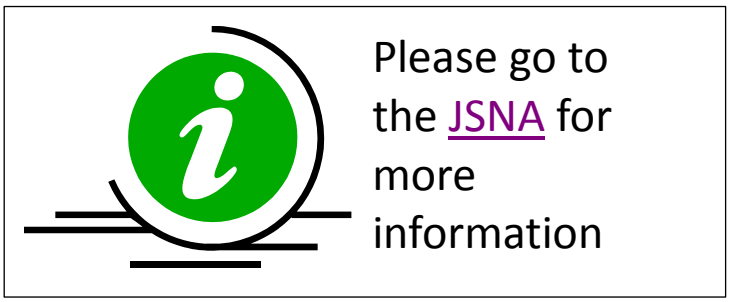
WHAT WE PLAN TO DO

Over the next five years we will:

- Support the Bromley Homelessness Strategy and the implementation of the action plan resulting from this strategy

HOW WE WILL MEASURE SUCCESS

The appropriate partners will decide on a set of outcomes for the action plan and will monitor the progress towards these. A progress update will need to go to the Health and Wellbeing Board twice a year.



PRIORITY 7 – ADULTS WITH A LEARNING DISABILITY WHO LIVE IN STABLE AND APPROPRIATE ACCOMMODATION

WHY IS IT IMPORTANT

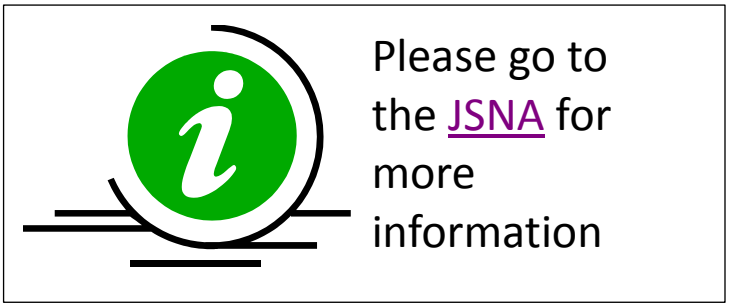
- Only 43% (170) of adults in Bromley with a learning disability live in stable and appropriate accommodation compared to 76% nationally
- In 2011/12, more than half of the adults with a learning disability lived in stable and appropriate accommodation (57.6%, n=550) compared to England (70%)
- Although in 2014/15, the rates in Bromley increased to levels similar to England (71% compared to 74%), this increase was not sustained and rates are trending steeply downwards
- Looking back to 2011/12 and now, there is a widening gap between Bromley and the England average

WHAT WE PLAN TO DO

The appropriate partners will identify the areas that should be prioritised and how they will be implemented. An action plan will be developed by appropriate partners.

HOW WE WILL MEASURE SUCCESS

The appropriate partners will decide on a set of outcomes for the action plan and will monitor the progress towards these. A progress update will need to go to the Health and Wellbeing Board twice a year.



PRIORITY 8 – DRUGS & ALCOHOL IN YOUNG PEOPLE

WHY IS IT IMPORTANT

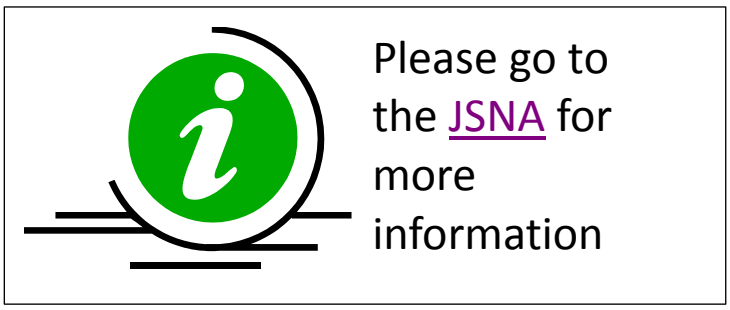
- High levels of alcohol consumption are associated with increased risk taking among young people, including; unsafe sex and drink driving.
- It is also a common feature of domestic and sexual violence.
- Among young people, drug use is linked to increased likelihood of a range of adverse experiences and behaviour including; truancy, exclusion from school, homelessness, time in care and serious or frequent offending.
- Rates in Bromley are higher than England for both regular drinkers and proportion of young people who had been drunk in the previous 2 weeks.
- Drug use is higher in Bromley than London.
- The number of young people presenting to specialist substance misuse services is falling.
- The main substance used by those attending services are cannabis and alcohol.
- Hospital admission rates for substance misuse for 15-24 year olds is worse than London and England.

WHAT WE PLAN TO DO

The appropriate partners will identify the areas that should be prioritised and how they will be implemented. An action plan will be developed by appropriate partners.

HOW WE WILL MEASURE SUCCESS

The appropriate partners will decide on a set of outcomes for the action plan and will monitor the progress towards these. A progress update will need to go to the Health and Wellbeing Board twice a year.



PRIORITY 9 – YOUTH VIOLENCE

WHY IS IT IMPORTANT

- Metropolitan Police data (MOPAC) for the whole of London shows gang activity makes up a small proportion of serious youth violence (less than 5% in 2015/16), and GLA Peer Outreach indicated much of the violent activity involved peer groups
- The data also shows knives were a factor in around half of youth violence in 2015/16
- Girls now make up almost a quarter of victims of serious youth violence, and there are also indications of an increasing number of young women committing serious violence
- There appears to be a mismatch between the perception of crime and violence and the reality for many young people in Bromley
- In Bromley there were 51 victims of knife crime injury aged 1-24 years in 2017
- 257 victims of serious youth violence in 2017
- 14 gang linked offences in 2017
- 3,686 under 18 victims of crime in 2016-2018
- Public perceptions of crime in Bromley are; 6% think gangs are a problem, 5% think knife crime is a problem, 3% think gun crime is a problem

WHAT WE PLAN TO DO

The appropriate partners will identify the areas that should be prioritised and how they will be implemented. An action plan will be developed by appropriate partners.

HOW WE WILL MEASURE SUCCESS

The appropriate partners will decide on a set of outcomes for the action plan and will monitor the progress towards these. A progress update will need to go to the Health and Wellbeing Board twice a year.

Please go to the JSNA for more information

PRIORITY 10 – ADOLESCENT MENTAL HEALTH

WHY IS IT IMPORTANT

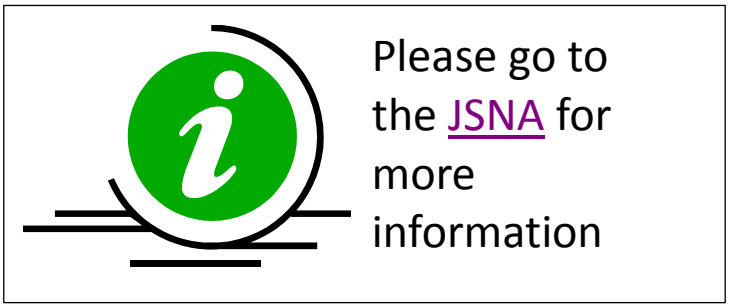
- Demand for early intervention services is increasing each year, the majority because of relationship, school or family issues
- Anxiety and mood problems are mentioned in more than half of the cases
- Of particular concern are the hundreds of children and young people presenting with self-harm, suicidal thoughts, or even a history of suicide attempts (66 young people between April and December 2017)

WHAT WE PLAN TO DO

The appropriate partners will identify the areas that should be prioritised and how they will be implemented. An action plan will be developed by appropriate partners.

HOW WE WILL MEASURE SUCCESS

The appropriate partners will decide on a set of outcomes for the action plan and will monitor the progress towards these. A progress update will need to go to the Health and Wellbeing Board twice a year.



NEXT STEPS TO ACHIEVING OUR VISION

This Health and Wellbeing Strategy has set out our vision and the priorities that we believe will enable us to achieve it. We have set out our priorities of work and an outline of how we will work and commission services for Bromley, however the key to achieving our vision and priorities lies in how we implement this strategy.

This strategy has been jointly produced by London Borough of Bromley and its partners and agreed by the Health and Wellbeing Board.

Alongside this strategy there will be an action plan for each individual priority area with lead organisations (please see the appendices for copies of these action plans) which will clearly set outcomes and targets and how partners will work together to achieve each priority. We will be asking groups to develop more detailed action plans.

Overall the action plans and progress will be reported to the Health and Wellbeing Board twice a year.

SUPPORTING STRATEGIES AND ACTION PLANS

The Health and Wellbeing Strategy does not exist in isolation. It brings together the strategies of all its partners to deliver and support its priorities. This is shown in the table below:

	Priority 1 Cancer	**Priority 2** Diabetes/obesity	**Priority 3** Dementia	**Priority 4** Suicide Prevention	**Priority 5** Statutory Homelessness	**Priority 6** Adults with a learning disability who live in stable and appropriate accommodation	**Priority 7** Drugs and alcohol in young people	**Priority 8** Youth violence
Building a Better Bromley – 2020	✓	✓	✓	✓	✓	✓	✓	✓
Children and Young People's plan 2018-2021							✓	✓
Bromley CCG Integrated Commissioning Plan 2014-2019	✓	✓	✓	✓	✓	✓	✓	✓
Homelessness Strategy 2018-2022					✓			
Education, Care and Health Business Plan 2018-2022	✓	✓	✓	✓	✓	✓	✓	✓

APPENDICES – PROPOSED DELIVERY OF THE STRATEGY

The strategy is a developing document. The next stage in delivery of the strategy is to work with groups and partners to develop individual action plans for each of the priority areas. Once these action plans have been developed the London Borough of Bromley Public Health Team will work with the groups to manage the action plans and ensure regular reporting to the Health and Wellbeing Board.

APPENDICES – ACTION PLANS

ACTION PLAN - PRIORITY 1 - CANCER

Task / Area	Lead Organisation	What we want to achieve?	What the measurable outcomes will be

ACTION PLAN - PRIORITY 2 - OBESITY

Task / Area	Lead Organisation	What we want to achieve?	What the measurable outcomes will be

ACTION PLAN – PRIORITY 3 - DIABETES

Task / Area	Lead Organisation	What we want to achieve?	What the measurable outcomes will be

ACTION PLAN - PRIORITY 4 - DEMENTIA

Task / Area	Lead Organisation	What we want to achieve?	What the measurable outcomes will be

ACTION PLAN – PRIORITY 5 – SUICIDE PREVENTION

Task / Area	Lead Organisation	What we want to achieve?	What the measurable outcomes will be

ACTION PLAN – PRIORITY 6 – STATUTORY HOMELESSNESS

Task / Area	Lead Organisation	What we want to achieve?	What the measurable outcomes will be

ACTION PLAN – PRIORITY 7 – ADULTS WITH A LEARNING DISABILITY WHO LIVE IN STABLE AND APPROPRIATE ACCOMMODATION

Task / Area	Lead Organisation	What we want to achieve?	What the measurable outcomes will be

ACTION PLAN – PRIORITY 8 – DRUGS AND ALCOHOL IN YOUNG PEOPLE

Task / Area	Lead Organisation	What we want to achieve?	What the measurable outcomes will be

ACTION PLAN – PRIORITY 9 – YOUTH VIOLENCE

Task / Area	Lead Organisation	What we want to achieve?	What the measurable outcomes will be

ACTION PLAN – PRIORITY 10 – ADOLESCENT MENTAL HEALTH

Task / Area	Lead Organisation	What we want to achieve?	What the measurable outcomes will be

THIS HEALTH AND WELLBEING STRATEGY HAS BEEN CREATED BY THE FOLLOWING PARTNERS:

Bromley
THE LONDON BOROUGH

NHS
Bromley
Clinical Commissioning Group

Bromley
Safeguarding
Adults Board

BROMLEY
SAFEGUARDING
CHILDREN
BOARD

COMMUNITY
LINKS BROMLEY

healthwatch
Bromley

This page is left intentionally blank

Report No.
CS18185

London Borough of Bromley

Decision Maker:	**HEALTH AND WELLBEING BOARD**
Date:	**27th September 2018**
Title:	**UPDATE ON DELAYED TRANSFERS OF CARE (DTOC) PERFORMANCE**
Contact Officer:	Jodie Adkin, Associate Director: Urgent Care, Discharge Commissioning & Transfer of Care Bureau, LB Bromley/Bromley Clinical Commissioning Group Tel: 07830 496 492 E-mail: jodie.adkin@bromley.gov.uk
Ward:	Borough-wide

1. Summary

1.1 A Delayed Transfer of Care (DToC) Performance update was circulated to Health and Wellbeing Board members on 7th June 2018. This included an update on performance to date, invalidated out of borough hospital reporting as well as Mental Health DToC validation processes and performance improvement.

1.2 This paper provides:

- Update from national departments on future DToC target (see section 4)
- Local and National Performance Update (see section 5)
- Update on invalidated data reporting by out of borough hospitals (see section 6)
- Mental Health DToC validation processes and performance improvement (see section 7)

2. Reason for Report going to Health and Wellbeing Board

2.1 The paper provides an information update to the Health and Wellbeing Board.

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

3.1 The Health and Wellbeing Board is requested to note the information update.

Health & Wellbeing Strategy

1. Related priority: Not Applicable

Financial

1. Cost of proposal: Not Applicable

2. Ongoing costs: Not Applicable

3. Total savings: Not Applicable

4. Budget host organisation: Not Applicable

5. Source of funding: Not Applicable

6. Beneficiary/beneficiaries of any savings: Not Applicable

Supporting Public Health Outcome Indicator(s)

Not Applicable

---

4. COMMENTARY

4.1 UPDATE FROM NATIONAL DEPARTMENTS ON FUTURE DTOC TARGET

4.2 Communication was received on 15 May 2018 updating local areas that nationally a revised methodology has been agreed to centrally set DToC targets. The information suggests that the methodology for the local target will be simplified using published data from winter between Septembers to December 2017. This differs from the previous year, which used one month and during the summer period creating an extremely challenging target that did not reflect seasonal variation.

4.3 The table below shows a breakdown of the DToC targets from Bromley, calculated from the national published objective by NHS England. The target has increased for Bromley from 10.31 bed days/day to 12.5.

DToC's Beds Per Day

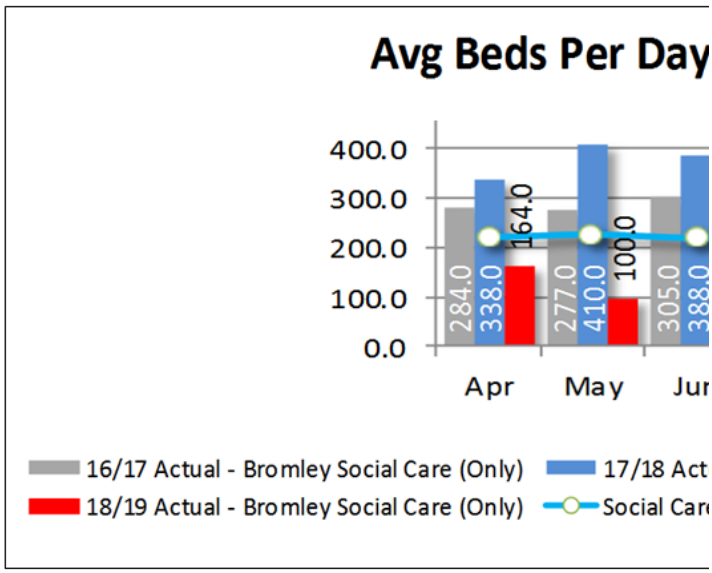
	17/18 Targets	18/19 Proposal	Var +/-
NHS	3.7	4.9	⇧ 1.2
Social Care	6.6	7.3	⇧ 0.7
Both	0	0.3	⇧ 0.3
Total	10.3	12.5	2.2

5. LOCAL AND NATIONAL PERFORMANCE UPDATE

5.1 The table below shows the overall performance for the 1st quarter of 2018/19 for the reported total delayed days of each month against the nationally set targets. Positive results were attained with each month achieving above the monthly set target.

	April	Target	Variation	**May**	Target	Variation	**June**	Target	Variation
NHS	**155**	147	-8	**144**	151	7	**77**	147	70
Social Care	**164**	219	55	**100**	226	126	**62**	219	157
Both	**51**	9	-42	**3**	9	6	**0**	9	9
Total (bed days)	**370**	375	**5** (1.3%)	**247**	387	**140** (36%)	**139**	375	**236** (63%)

5.2 The chart below shows a year on year improvement in DToC attributed to Bromley Social Care during the first quarter of the year.



5.3 June 2018 recorded an overall of 139 days beds attributed across all areas; this compares with 490 from the previous year – a reduction of 351 (72%). Of these, 55% were attributable to the NHS and 45% to Social Care.

5.4 This figure represents 0.1% of the nationally published data of 134,300 total delayed days in June 2018.

5.5 For Social Care, the figure for the most recent published month (June 2018) confirms a daily average of 4.6 against the 7.3 days target.

5.6 The overall DToC distribution year-to-date for Bromley was; 50 % for the NHS, 43% for Social Care and 7% attributed to both. This compares to; 23% for the NHS, 77% for Social Care and 0.5% attributed to both for 2017/18.

5.7 Nationally for 2018 (year-to-date), overall Bromley (across all areas) has been responsible for 756 days at an average of 8.3 per day.

5.8 This compares with a figure of 1484 (16.3 beds per day) for the same period in 2017/18 – a reduction of 50.9% (see appendix 1), taking Bromley from the poorest performing authority to the 2nd best local authority out of the South London area.

6. UPDATE ON INVALIDATED DATA REPORTING BY OUT OF BOROUGH HOSPITALS

6.1 A more resilient infrastructure has been put in place to ensure all out of borough hospital data is validated before submission, particularly in neighbouring boroughs where there was an issue historically. Data is agreed on a weekly basis with a review of the reason and attributed authority. This has significantly improved discrepancies between national submissions and locally agreed figures.

7. IMENTAL HEALTH DToC VALIDATION PROCESSES AND PERFORMANCE IMPROVEMENT

7.1 The Mental Health DToC Partnership Group which brings together the Local Authority, CCG and Oxleas Foundation Trust has continued to develop systems processes and management oversight to reduce DToC across Oxleas following a peak in activity in Q3 2017/18 which reported an average of 250 delayed days per month, 8.3 clients per day.

7.2 As a result of this work the DToC in MH acute trusts has now come down drastically with Q1 figures reducing as follows, this is amongst the highest performance nationally for Mental health Delays:

	April	May	June	**Total**
Validated Month Totals	103	13	11	**127**

7.3 In addition there has been a retrospective cleanse of DToC figures which will reduce the national submission by 440 for Q4 2017/18. This will show in the national data in the coming months. The table below shows the original return against the updated validated monthly totals.

	January	February	March	April	May	June
Validated Month Totals	140	143	103	103	13	11
Original UNIFY Return Totals	**326**	**247**	**253**	**122**	**13**	**11**
Change	-186	-104	-150	-19	0	0

7.4 To sustain this improved performance position the following has taken place:

- 10 discharge pathways have been mapped and shared with all relevant partners with specific work taking place to increase the access to Reablement and Extra Care Housing for people with mental ill-health
- A robust monitoring and validation process is in place, with weekly DToC and potential DToCs being considered by a multiagency group, as well as formal updates provided to Adult Mental Health Practice Review Group (PRG) chaired by the Director Adult Social Care. All data is formally agreed by the DAS and MD of CCG before any national submission is made.
- An Action Plan has been developed by the Trust to address all issues identified by the Task and Finish Group and will be monitored as part of the ongoing contract monitoring of Oxleas by the CCG

7.5 DToC figures are reduced to a minimum, with the current objective being to identify any potential delayed discharges and taking necessary measures to prevent these from developing into formal DToCs. More recently, there has been 0 DToCs for a number of weeks across Oxleas services.

8. FINANCIAL IMPLICATIONS

8.1 A joint letter from the Secretary of State for Health and for Department of Communities and Local government to the Leader of the Council dated 5 December 2017 confirmed that 'there will be no impact on your additional iBCF allocation in 2018/19.'

Non-Applicable Sections:	Legal Implications, Implications for other Governance Arrangements, Boards and Partnership Arrangements, including any Policy and Financial Changes required to Process the Item, and Comment from the Director of Author Organisation.
Background Documents: (Access via Contact Officer)	Not Applicable.

SECTION 1 (COMPARATOR DATA)

Actual Total Delayed Days Local Authority			
Attributable to NHS ONLY	**Apr-18**	**May-18**	**Jun-18**
Bexley	161	215	136
Bromley	155	144	77
Croydon	338	426	400
Greenwich	125	147	48
Lambeth	200	316	382
Lewisham	190	134	208
Our Ranking (0 = Best; 6 = Worst)	**2**	**2**	**2**

Attributable to Social Care ONLY	**Apr-18**	**May-18**	**Jun-18**
Bexley	194	78	93
Bromley	164	100	62
Croydon	344	349	236
Greenwich	127	87	102
Lambeth	338	147	141
Lewisham	72	48	14
Our Ranking (0 = Best; 6 = Worst)	**3**	**4**	**2**

Attributable to Both	**Apr-18**	**May-18**	**Jun-18**
Bexley	0	0	0
Bromley	51	3	0
Croydon	98	41	30
Greenwich	0	0	0
Lambeth	90	94	60
Lewisham	6	0	0
Our Ranking (0 = Best; 6 = Worst)	**4**	**4**	**1**

Source: Statitiscs derived from NHS England – https://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/statistical-work-areas-delayed-transfers-of-care-delayed-transfers-of-care-data-2018-19/

Report No.
CS18183

London Borough of Bromley

Decision Maker:	**HEALTH AND WELLBEING BOARD**
Date:	**27th September 2018**
Title:	**BROMLEY SYSTEM WINTER PLAN**
Contact Officer:	Clive Moss, Urgent Care Lead, Integrated Commissioning, Bromley Clinical Commissioning Group Tel: 07864969693 E-mail: clive.moss@nhs.net
Ward:	Borough-wide

1. Summary

1.1 The overall aim of the plan is to provide a framework for health and social care partners in the Bromley system to manage surge and capacity issues affecting one or more partners at both tactical and strategic levels. Furthermore, to support the local health and social care system effectively manage winter pressures, the SEL STP has asked for a winter assurance plan from each Local A&E Delivery Board for submission to NHS England. The whole health economy is encouraged to use this plan to manage pressures on respective parts of the system.

2. Reason for Report going to Health and Wellbeing Board

2.1 The Bromley System Winter Plan is being presented to the Health and Wellbeing Board as part of the local assurance scrutiny and assurance process.

2.2 The Health and Wellbeing Board are requested to support and challenge the local system to ensure the elements included in the report are delivered and the local system works together to respond to the challenging seasonal demand.

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

3.1 This is a system wide Plan which includes input and support from all Bromley partners. Specific individuals and organisations are identified throughout for their role in delivering the Plan. The A&E Delivery board has oversight of the activity delivered under the Plan.

Health & Wellbeing Strategy

1. Related priority: [Delete as appropriate] Not Applicable

Financial

1. Cost of proposal: 2,647,000: £628k (CCG) £1,027k (LBB), £992k (King's)

2. Ongoing costs: No Cost:

3. Total savings: Not Applicable:

4. Budget host organisation: LBB and King's

5. Source of funding: Better Care Fund

6. Beneficiary/beneficiaries of any savings: Not Applicable

Supporting Public Health Outcome Indicator(s)

4.11 - Emergency readmissions within 30 days of discharge from hospital
4.13 - Health related quality of life for older people
4.15iii - Excess winter deaths index (3 years, all ages)
4.15iii - Excess winter deaths index (3 years, over 85)

---

4. COMMENTARY

4.1 The purpose of the Bromley System Winter Plan is to both support and enhance the effectiveness of local procedures through proactive management processes at times of pressure and provide local and national assurance of how existing and additional resources will work together to respond to the additional seasonal demand. Objectives of this plan are:

- To establish a shared understanding of different surge and escalation criteria used across health and social care services
- To define a flexible framework for response which can be utilized irrespective of situation duration, scale and type
- To define procedures and processes about escalation to be utilised in the event of an actual or potential surge and capacity issue(s)
- To provide a framework for identifying specific surge and escalation issues and for informing, coordinating and supporting the local health and social care services response to an incident
- To provide a framework for actively engaging with the public both in advance of and during surge and escalation situations with a view to assisting in the management of surge and escalation issues. Links to winter communication campaign.
- To provide a mechanism to escalate issues for joint resolution by partners at both a tactical and a strategic level

5. IMPACT ON VULNERABLE PEOPLE AND CHILDREN

5.1 The Plan ensures the system are held to account in their role in ensuring Bromley residents have access to timely, high quality health and social care when they need it preventing. In particular the plan ensures there is apprpraite resource for frail and elderly residents who are particularly vulnerable to seasonal illness.

6. FINANCIAL IMPLICATIONS

6.1 The CCG and LBB Winter resilience funding is part of the agreed Bromley Better Care Fund. King's winter resilience funding is part of their contracted baseline.

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

7.1 A&E Delivery Board is responsible for the oversight and management of the Bromley System Winter Plan

8. COMMENT FROM THE DIRECTOR OF AUTHOR ORGANISATION

8.1 For the first time Bromley has developed a truly integrated plan on how the whole system will work together to manage the significant additional pressures that we see throughout winter months to ensure Bromley residents are able to have access to the services they need. The Plan is essential in ensuring all partners are supporting the acute hospital so very sick patients that need hospital based care are able to be seen in a timely way.

Non-Applicable Sections:	Legal Implications.
Background Documents: (Access via Contact Officer)	Not Applicable.

This page is left intentionally blank

Bromley Whole System Winter Plan

Version control

Date	Responsible person for changes	Version	Status
14.09.2018	Clive Moss – Urgent Care Lead	v0.1	To AEDB for discussion
14.09.2018	Clive Moss – Urgent Care Lead	v0.2	Changes following AEDB discussion. To STP for comment.
17.09.2018	Jodie Adkin	V0.3	Additional amendments

Document Maintenance

Document Name:	***Bromley Whole System Winter Assurance Plan***
Author:	
Plan Owner:	Bromley Clinical Commissioning Group
Agreed / Ratified	Bromley A&E Delivery Board
Issue Date:	
Review Date:	

Control

This a controlled document maintained by Bromley Clinical Commissioning Group

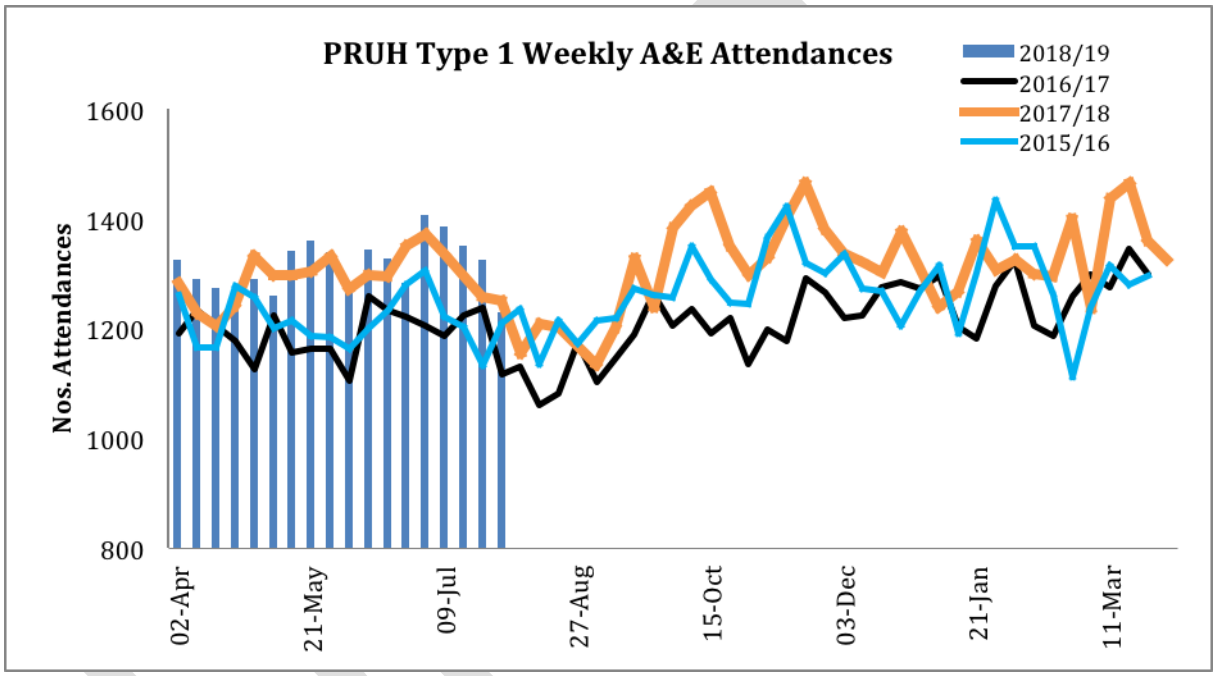
1 CONTENTS

2 PURPOSE OF THE PLAN

2.1 BACKGROUND:

Over the past few years, the local health and social care system has felt the increased pressure during the winter months, with most health and social care services seeing a surge of activity and demand with a more complex range of needs challenged by seasonal presentations like Flu and norovirus. ED type 1 attendances have increased year on year during the winter period (see table 1).

Table 1



The additional pressures on the health and social care system, which are primarily from older and frail people, during the winter months presents a challenging landscape. Bromley wider health and social care system leaders have developed this plan to manage safely and effectively the additional pressures during this period.

This plan was developed through the Bromley A&E Delivery Board, which delivers a whole systems approach to planning, improved performance and the development of a coherent local service framework for urgent and emergency care. This approach includes coordinated planning for and management of winter pressures, and other periods of enhanced demand on the care system. The Board is facilitated by Bromley CCG, working in partnership with King's College Hospital, London Borough of Bromley, Greenbrook Healthcare, Oxleas NHS Foundation Trust, Bromley Healthcare, Bromley GP Alliance, St Christopher's and London Ambulance Service.

2.2 AIMS AND OBJECTIVES

The overall aim of the plan is to provide a framework for health and social care partners in the Bromley health and social care system to manage surge and capacity issues affecting one or more partners at both tactical and strategic levels. Furthermore, to support the local health and social care system effectively manage winter pressures, the SEL STP has asked for a winter assurance plan from

each Local A&E Delivery Board for submission to NHS England. The whole health economy is encouraged to use this plan to manage pressures on respective parts of the system.

The purpose of this plan is therefore to both support and enhance the effectiveness of local procedures through proactive management processes at times of pressure and provide local and national assurance of how existing and additional resources will work together to respond to the additional seasonal demand. Objectives of this plan are:

- To establish a shared understanding of different surge and escalation criteria used across health and social care services
- To define a flexible framework for response which can be utilized irrespective of situation duration, scale and type
- To define procedures and processes about escalation to be utilised in the event of an actual or potential surge and capacity issue(s)
- To provide a framework for identifying specific surge and escalation issues and for informing, coordinating and supporting the local health and social care services response to an incident
- To provide a framework for actively engaging with the public both in advance of and during surge and escalation situations with a view to assisting in the management of surge and escalation issues. Links to winter communication campaign.
- To provide a mechanism to escalate issues for joint resolution by partners at both a tactical and a strategic level
- To provide oversight of proactive work by all partners to reduce escalation of need and respond to increased pressures in the system

3 APPROACH TO ESCALATION

System demand and capacity, including flexing staff/beds into non-elective setting

3.1 DEFINITIONS

It is recognised that, at any one point in time across our system, organisations may be at different levels of escalation in line with their view on pressures that may be individual to their organisation. However, there is agreement that armed with knowledge about the pressures across the system and using principles of mutual aid the system will be in a better position to be able to cope.

Green	Amber	Red	Black
Business as usual. Low risk to patient safety and experience, slight effect on services where early signs of difficulty are being detected requirement management intervention	Moderate effect on services. Moderate risk to patient safety and experience where increasing flow issues are being detected requiring significant additional action	Severe and/or prolonged pressure on services. High risk to patient safety and experience where demand for services is outstripping supply or patient flow is severely impeded	Extreme effect on services. Significant Incident declared. Very high risk to patient safety and experience. Services are overwhelmed by levels of demand

The above table highlights the definition of each escalation stage, from green to Black, the system wide engagement and involvement is automatically triggered at the **Amber** stage and those involved will seek to return the system to **Green**. If this is not possible senior management escalation across the health and social care economy will be triggered at the **Red** status.

3.2 ESCALATION PRINCIPLES WITHIN BROMLEY

1) Each major service provider is expected to manage the escalation and de-escalation processes at local level and this framework outlines these arrangements
2) The CCG will use whole system daily Surge Hub calls to co-ordinate a response to an escalating situation.
3) Each major service provider must have a robust, up-to-date local escalation plan signed off at Board level which dovetails into this overarching CCG wide plan.
4) The acute trust is also required to have an ambulance services handover plan and to comply with its obligations (please refer to Section 5.3 for detail).
5) Within each organisation there are clear system leaders (including identification of organisation, role/s and responsibilities) which will oversee all levels of escalation, especially those where whole system action is needed to avoid or mitigate pressure, and where

external support might be required (please refer to Appendix 1). Further escalation should be to the agreed Urgent and Emergency Care System Leader.

6) Where an organisation has undergone escalation of status a nominated staff member within each organisation will agree and lead the de-escalation process once review shows suitably reduced pressure.
7) Each organisation must have an identified individual who is responsible for ensuring that escalation plans are actioned and reviewed. This person must have suitable authority to ensure actions occur in a timely manner.
8) For any patients that are moved during escalation, plans must be in place for their repatriation (see Section 5.2).

Risk factors

The following factors increase the risk of there being a surge in demand for services:

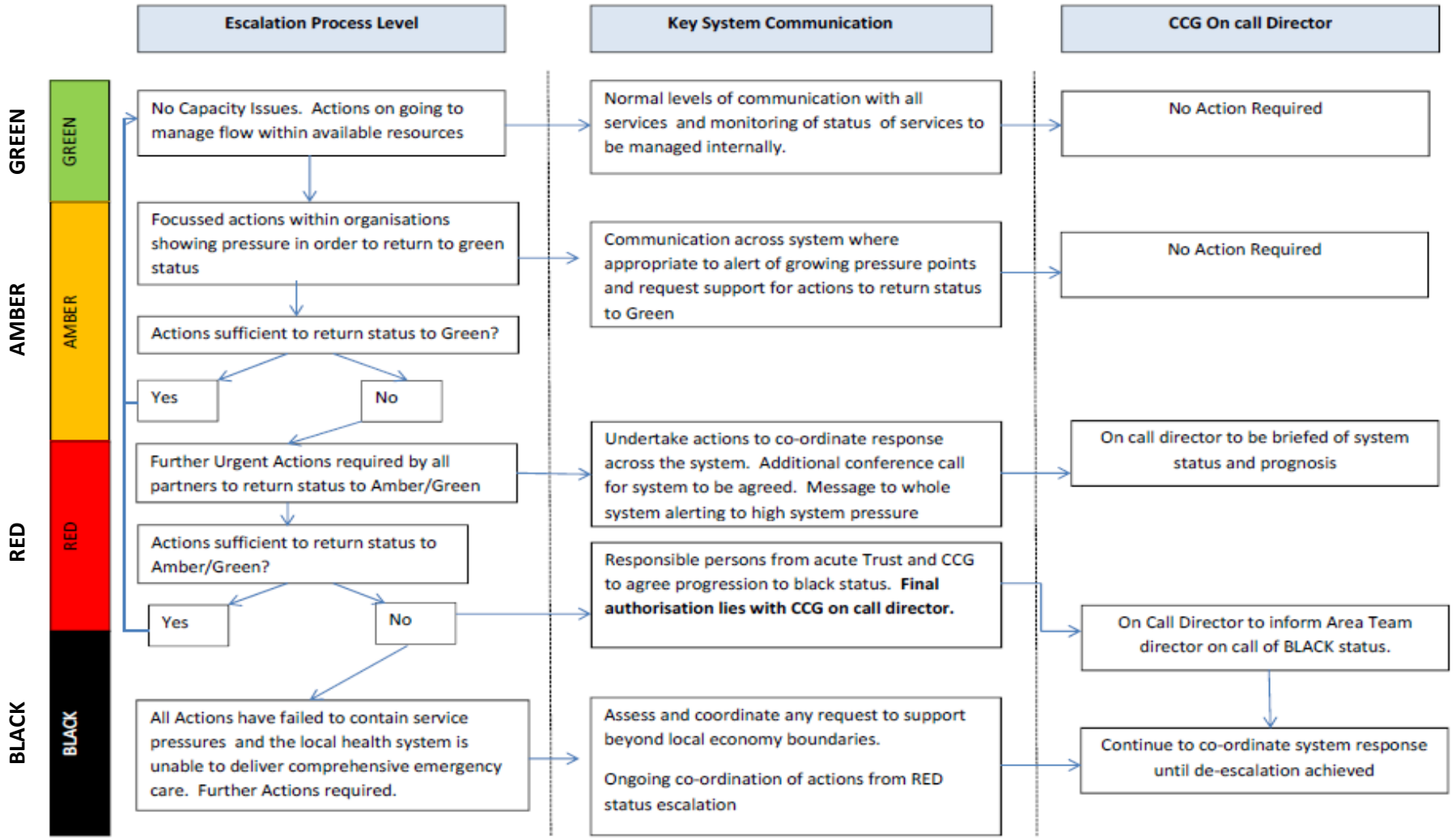
- Severe winter weather
- Heatwave conditions
- A Major Incident with severe and multiple casualties
- Pandemic influenza or other infectious disease outbreaks
- Disruption to community care and/or social care services
- Extended Bank Holiday Weekends causing increased demand on both Acute Trust and OOHs services

Whole System Factors

Increased activity in the acute care setting could subsequently result in a delay in the community and social care settings as the demand for their services increase. Communication of a surge and the opening of escalation capacity with these groups will be essential for a return to normality following the surge. Failure to notify the following groups may further increase the surge in demand by creating feedback into the acute setting where patients are unsupported on discharge:

- GP Practices
- Social Services
- Bromley Healthcare – Rapid Response, Bed Based / Home Based Rehab and Community Nursing
- St Christopher's
- Oxleas Community Mental Health Teams
- Transfer of Care Bureau

Escalation Communication Flowchart



4 ESCALATION PLANS FOR MANAGING SURGES

4.1 KCH PRUH

Appendix 2 details the Internal Incident Plan, which seeks to clarify how the Trust responds to a surge or collective number of patients within the Emergency Department which may compromise their safety, and require an advanced and controlled hospital response.

The plan is also suitable to deal with high capacity within the hospital. No two scenarios are alike; therefore, the plan is designed to provide a framework to enable staff to respond flexibly and appropriately to the situation.

The following procedure is to assist the organisation to respond in a co-ordinated uniform manner to ensure the safety of staff, the public and patients under their care and to ensure continuity of business of the Trust.

The KCH PRUH management team are currently refreshing the escalation process linked to OPEL scores, which we aim to complete by the end of the month. Appendix 3 is the PRUH Emergency Department Capacity Management Escalation Policy and action cards as an example, alongside Appendix 4 which is the full capacity dashboard which supports triggering between levels and the more general Trust internal incident process.

With regard to **system demand and capacity, including flexing staff/beds into non-elective** the PRUH site current demand and capacity shows a shortfall of c 60 beds following the closure of D2A capacity, Elizabeth Ward and internal escalation capacity. In terms of daily flexing of staff, this will be supported by the refreshed escalation/full capacity protocol.

4.2 PRUH AND BECKENHAM BEACON URGENT CARE CENTRES (UCC) – GREENBROOK HEALTHCARE

Appropriate Escalation is crucial to the safe management of the UCC. The lead nurse should ensure he/she is always aware if the status of the department and complete a Sitrep if the department is not in a Green position. Actions should be followed and documented on the sitrep form.

Greenbrook provide three times daily capacity and activity reports to the CCG and escalate to the contracts team where there may be issues with demand or capacity. See Appendix 5 for the PRUH and BB UCC Activity Escalation Plans and Action Cares.

4.3 BROMLEY HEALTHCARE

Agreed system triggers and appropriate actions

BHC has an internal 0830 resilience call where capacity and demand is discussed broadly covering Bed Based Rehab, Home Based Rehab, Rapid Response and District Nursing. The AD Operations is present on the call and relays the information to the 0930 system surge call. BHC respond to any escalation or activity required in order to support acute with flow by flexing resources wherever possible,.

Agreed escalation process for managing surges

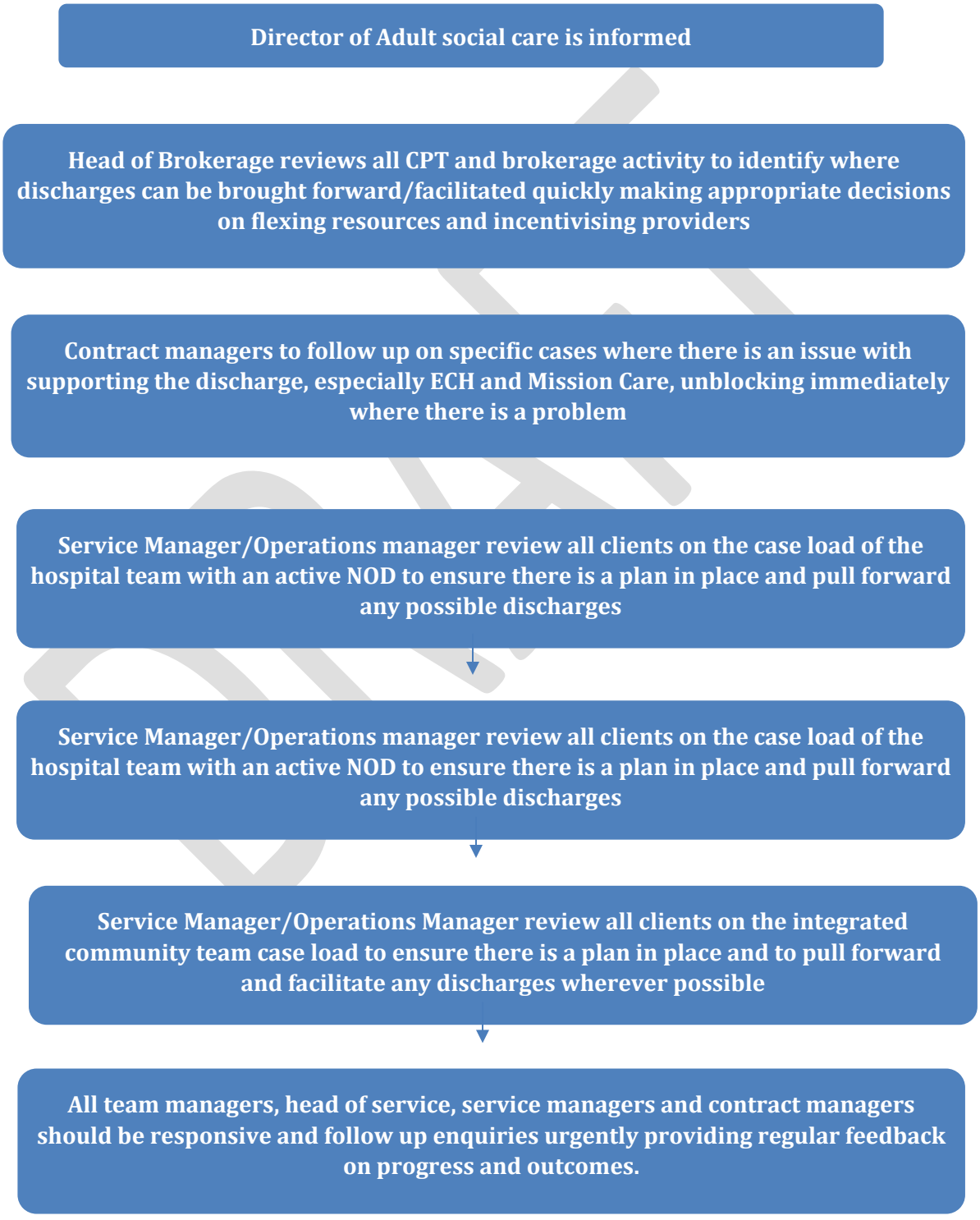
BHC report on the outcome of the 0830 and 0930 calls internally and any surge requirements are escalated through AD Ops to Director of Ops to CEO accordingly. BHC will dial into platinum calss when required.

4.4 OXLEAS NHS FOUNDATION TRUST

4.5 LONDON AMBULANCE SERVICE

4.7 London Borough of Bromley

Response to Acute escalation:



5 WINTER RESILIENCE SCHEMES 18/19

In the past few years LB Bromley (LBB) and NHS Bromley CCG (BCCG) have made financial investment to provide additional capacity to the system during winter months. Lessons learnt from 2016/17 was that new schemes during winter were not successful and often went underutilised. Last year, the enhancement of existing resources proved much more successful and although not meeting national standards, performance across the system was better than that of previous years with responsiveness and recovery rates considerably improving. King's College Hospital have also identified winter schemes this year and are detailed below (noting that there is £973k available already in the trust baseline for spending on winter schemes at the PRUH). For financial and KPI details around the proposed schemes please see Appendix 6 attached.

5.1 BROMLEY CCG AND LONDON BOROUGH OF BROMLEY

The CCG winter resilience funding (£628k budget) and London Borough of Bromley winter resilience scheme funding (£1027k) has been allocated across the health and social care system to ensure there is additional capacity in the system to ensure patients are seen in the appropriate care setting. This includes schemes to support patients in secondary, community and primary care (i.e. the additional GP hub appointments for patients). The CCG schemes have been signed off in principle by Bromley CCG Governing Body and are being fully worked up in partnership with providers. Each scheme will have a robust monitoring and evaluation process ensuring that the agreed KPIs are delivered. The LA are replicating the same activity from the previous year following positive evaluation of the impact of this resource.

The proposal for this year builds on lessons learnt from the previous year and focuses on three joint strategic themes which are *Increasing capacity in the workforce*, *Increasing capacity in service provision* and ***Integrating service to prevent the need for hospital based care and streamline discharge processes.*** From the evaluation of both organisations previous winter schemes, stakeholders agreed that increasing capacity in existing services, whilst strengthening the community reactive, urgent response offer would be an effective use of resources for 2018/19. A full list of the schemes including financial investment and KPIS can be found in appendix. The following provides a brief overview of areas associated with the three strategic themes:

1) Increasing capacity in the workforce

- Providing additional Care Management and Occupational Health professionals across the community and hospital to support additional demand
- Additional Support to Urgent Care Centre (soon to be designated Urgent Treatment Centres) (CCG) to increase productivity and manage additional activity

As commissioned last year, the three elements were:

- Extended patient champion hours which supports redirection and increases use of hub appointments including advise and sign-posting to reduce avoidance attendances
- Enhanced GP rates which last year resulted in 100% Rota fill across both sites including bank holidays and weekends enabling the UCCs to support ED and see as many patients as possible

- Increasing Health Care Assistants which allows clinical staff to focus on treating and discharges more patients with HCAs completing ECGs, observations, plastering and some dressings

2) Increasing capacity in service provision

- Additional GP appointments at the Primary Care Access Hubs (CCG)

As commissioned last year and the appointment slots were well utilised. In previous years, practice access to hub appointments has mitigated the increase in UCC attendance over the winter period and helps general practice to keep patients well and therefore avert crisis and possible A&E attendance.

- GP winter home visits (CCG)

The demand for home visits has increased by over 50% in the past two years, and feedback from the vast majority of practices shows that practices are finding it more and more difficult to meet this demand without there being an adverse impact on delivery of other primary care services. The timely provision of home visits will help prevent patients falling into crisis and therefore avert potential far costlier A&E attendances/admissions. The CCG intends to commission Bromley Healthcare to provide additional health care professional capacity to provide these home visits. Practices have reported that in the past ANPs have provided high quality care for patients that they have referred to the service.

- Fast Track Personal Care (LBB)

Providing access to increased domiciliary care at home including POC within 4 hours and up to 8 visits per day, bridging for reablement or where the existing market cannot meet presenting demand . Consideration for block funding bridging capacity during key periods is underway to ensure guarantees capacity this winter

- Intensive personal care services (LBB)

Additional access to increased domicilary care offer (usually maximum 4 visits per day) including 24hr care at home, live in carer and night sits as per successfully used in previous years to support more people to remain and be discharged home. Funding will also provide access to emergency placements to also prevent social admissions or hospital attendance.

- Decluttering and access to provision to support people to return home (LBB)

Commissioning a dedicated decluttering and deep cleaning service to ensure where care or equipment is required and the home is cluttered, this can be decluttered in a timely way to prevent a delay to discharge. In addition funding will be used for wider property protection and ensuring people who no longer have capacity and don't have power of attorney or support in place are able to access food and shopping while this process is undertaken all of which will have a positive impact on supporting timely discharge.

3) Bringing together service to prevent the need for hospital based care and streamline discharge processes

- Enhanced healthcare in care Extra Care Housing

Extra Care Housing provision is within the top 10 placements (ECH, Supported living, residential and nursing Care) in the borough for London Ambulance Service call outs. Conveyance and admissions rates however are proportionally lower then other placement providers. Extra Care housing, although has domiciliary care on site, does not benefit from a Visiting Medical Officer, and the level of care provided is considerably less then residential or nursing care. Schemes are often large in size and the level of need for many is increasing. The provision of a dedicated ANP/Community Matron will provide proactive support as part of the existing multidisciplinary team of ECH and care management staff, for provides to build capacity and ensure care plans are in place to manage declining and frail patients as well as the ability to caseload high risk, vulnerable patients with fluctuating health needs. In addition residents in ECH tend to spend longer in hospital with challenges in discharging people back to their accommodation with a number of readmissions. Support form the ANP/CM will enable early supported discharge for residents who have been admitted and ensure they are able to remain at home, preventing readmission for this group wherever possible.

- Bromley @home - will also support health and social care providers

The service aims to help prevent avoidable hospital attendances and admissions, reduce unnecessary readmissions and shorten hospital length of stay for residents of Bromley. The service will provide acute clinical care, in the persons' usual place of residence that would otherwise have to be undertaken in hospital, with the aim of providing the best possible patient experience and health outcomes enabling the patient to benefit from holistic integrated care.

Patients will be identified by LAS, GPs or community care providers as well as early identification at hospital front door assessment. The service will provide short-term medical treatment and associated monitoring supported by multidisciplinary interventions as required for any associated functional decline including physiotherapy and occupational therapy.

This pilot service model is majority funded through existed resource/capacity. Winter Resilience funding is being utilised to provide additional capacity where gaps exist in current services. Funding is currently indicative and the financial model is still being finalised with the provider(s). This service will be rolled out in a phased approached, firstly concentrating on referrals from the acute Emergency Department and GPs. This will be monitored daily with the next stage of roll out focusing on providing an alternative care pathway to London Ambulance Service, Care Homes and Domiciliary Care agencies.

Winter Communications Plan / Campaign:
There is funding set aside for local winter campaign material for the public. The CCG Communications and Engagement team will work with the national campaign team to coordinate effective and meaningful messaging to the Public before and throughout winter.

5.2 KING'S COLLEGE HOSPITAL PRUH SITE

Please see Appendix 6 for details on prioritised winter scheme spend.

6 5.0 Further System Winter Planning:

6.1 Infection control including flu vaccinations

6.1.1 Population

As part of the Bromley PMS Premium Services that Bromley GP Practices are required to deliver Childhood and flu immunisations uptake and follow up of non-responders. The national target is 75% for over 65s. This service is configured to reward both activity by the practice to increase uptake and uptake outturn and allows for a phased approach for the latter. Pharmacies in Bromley also provide the flu jab for the local population.

6.1.2 Health and care Professionals

Each provider is required to ensure that their staff are vaccinated in advance of winter, in line with the work undertaken at SEL level.

All LBB employees are able to take their ID to local pharmacies and commissioned providers to receive their FLU vaccination. All frontline workers are expected to have their flu vaccination.

6.2 Process for managing repatriations

KCH PRUH will be utilising the Surge Hub Repatriation Policy. The hospital also has an internal process that can be seen in Appendix 8.

6.3 Improving ambulance handovers

Substantial work has already been undertaken at the KCH PRUH site on improving ambulance hand over and in general the site's performance compares well. The action delivered is shown below:

No.	Area	Action	Lead & Timescale	Time scale	Progress Update	RAG Status	Impact on 4 hour standard
1.0	Improve ED Capacity/Patient Experience	Implement Fit to sit. Target to have 0 handover delays greater than 30minutes.	Chris Kerr	Feb-18	Fit to sit embedded from Feb 2018. SOP in progress to include clarification of inclusion and exclusion criteria (target date end of September) HCA and Nurse to be allocated to fit to sit area (Sept) PRUH site shows a 21% improvement in performance between January 2018 and June 2018. A shift from an average of 14.3 handovers over 30 minutes/day to 2.3.day on average in June.	Green	0.25%

6.4 MINOR BREACH REDUCTION

As part of the STP Minor Breaches Reduction plan, which forms part of the overall A & E Delivery Plan, KCH PRUH and Greenbrook UCCs are actioning the following to reduce breaches for 'minors' attendance:

Urgent Treatment Centres and Community Based Care

- 2 GP led Urgent Treatment Centres in Bromley provided by Greenbrooks one of which is on the same site as the PRUH – significant developments in partnership working and Standard Operating procedures are in place with the UTC to support effective streaming including direct access from GP referrals and LAS bypassing ED. Clinician to clinician hand overs also in place with daily huddles between clinicians to ensure the pressure and resource across the system is shared and understood
- An @home model in the community is under development to be mobilised before winter bringing together a range of existing resources to provide a responsive community based MDT to provide acute and sub-acute interventions in the community preventing attendances and avoiding hospital admission.
- An active GP out of hours service is in place with recent increase in capacity to support winter pressures. Ongoing review of supply and demand is undertaken by the CCG with flexible response to surge in activity.

Emergency Department

- Working to improve IT interface in place between Adastra and Symphony to have single system entry for all attendances seen through UCC. This will improve triage and streaming from UCC. IT project team in place and upgrade testing between the two systems completed week of 20 August. Results under review with team.
- UCC Referral to Assessment/ Ambulatory Units for Speciality Patients. Following trial of streaming patients in sub-acute to ambulatory (passed from UCC to ED), PRUH ED to work with UCC on how to directly refer where appropriate.
- An advanced nurse practitioner triage system is in place at all times with dedicated frailty nurse placed within ED to identify and stream patients appropriately
- Significant transformation activity is taking place across the PRUH including refreshed ED surgical pathway, Frailty Assessment Unit and Rapid Assessment and Treatment (RATT) to provide dedicated specialities into ED and ensure people are streamed to the most appropriate place to meet their needs.
- A frequent attenders meeting takes place with input from community services to identify interventions and support to reduce attendances. This is further supported by the Proactive Care Pathway delivered through 3 Integrated Care Networks to support more people to remain independent in the community for longer

System leadership and Governance

- The A&E Delivery Board provide system leadership to continue to reduce all type 1 breaches including level 4.
- Daily performance review is undertaken on all breaches across the system with a scrutiny report provided by providers to commissioners on reason and actions to address. Thematic analysis taking place on a monthly basis and fed into the A&EDB. Where capacity is an issue, a flexible

approach to resources across the system is used. During seasonal and high pressure times additional primary care capacity is put in place to provide increased support to the system
- The A&E Delivery Board continues to provide oversight, scrutiny and leadership on system wide improvement around Urgent and Emergency care pathways and performance
- Within contractual agreements is has been made clear that the CCG have a zero tolerance response to breaches from all providers

6.5 Provision of an Out of Hospital borough-based service map, including referral and access criteria.

Please see Appendix 8 for the Bromley OOB Referral Process Map. This is intended to be a live document, updated as new service information i.e. winter schemes, becomes readily available. In addition the local escalation contact list (see Appendix 1) has been developed to ensure the correct professionals are in place to support any issues.

6.6 Further Provider Assurance Plans

In advance of winter, the CCG also asked providers to give assurance that there were plans in place to:

1) *Identify and proactively plan/track at risk residents and ensure all care plans are accessible should a crisis occur*
2) *Avoid emergency attendance and admissions:*
3) *Ensure timely discharge for medically fit patients requiring ongoing care and support e.g. trusted assessor, referring and assessment to community services pre-MSFT to ensure all in place once patient is MSFT, services accessed via single passport document not separate referral form*
4) *Maintain people in the community reducing escalation of need*
5) *Specific plans to ensure full 7 day service is in place*

6.6.1 Identify and proactively plan/track at risk residents and ensure all care plans are accessible should a crisis occur?

King's College Hospital PRUH

- Early identification of people with frailty on presentation to UCC.
- Re-run audit of patients attending 5 or more times in the last year. Will engage CCG to write to GP and, where relevant, nursing or care home where the patient resides. Request GP review care plan for the patient.
- Staff in hospital aware of and using information through red bag scheme. (Clarifications required around discharge information)

Bromley Healthcare

- BHC Wrap around services: Proactive Care Pathway-linked to ICN hubs; Respiratory Team; Community Matrons; Children's Community Nursing Team; District Nursing Teams; Night nursing; Neuro Rehab team; Bed and Home Based rehab.
- BHC will ensure these wrap around services winter plans are in place at an early stage.
- BHC will ensure all patients and carers have relevant contact details and will ensure administrators in the CCC are briefed with regards to our winter plan.

London Borough of Bromley

- Care & support plans uploaded onto CareFirst (data systems), accessible across the organisation as well as to health colleagues via Multi-Agency View (MAV) of CareFirst
- Proactive work with carers to ensure care and support plans and effective contingency plans are visible on both the carer and adult they care for record

Oxleas

- Admission prevention: tightening up on crisis and contingency plans - programme in place with clinical reference board for each team to come to and discuss plan. Everyone on CPA but also include paragraph for outpatients. Oxleas can also now access the local care record to access patient record.

St Christopher's

- All patients known to St Christopher's, with patient consent are added to Coordinate My Care which can be accessed by healthcare professionals including LAS, GPs and KCH palliative care team.

6.6.2 Avoid emergency attendance and admissions:

King's College Hospital PRUH

- Geriatrician advice line available to community healthcare professionals.
- Internal professional standard for specialty response to ED to enable early senior input to patient admission/discharge plan. Additionally, the Trust does not admit patients who are likely to be able to go home from the ED to avoid a breach of the emergency care quality indicators.

Bromley Healthcare

- Additional funding to provide the extension of the GP winter visiting scheme which was successful last winter (see CCG winter schemes)
- Additional funding for a Community Matron / ANP to work with the Residential Homes and Extra Care Housing to carry out Geriatric Assessments and review via MDT via the Proactive Care Pathway. Provide direct clinical care to patients to prevent ED attendance where possible. Also link in with the other ICN strategies including End of Life and Heart Failure for these patients. Provide support to homes regarding patient deterioration and education(see CCG winter schemes).
- Obtain data from LAS and PRUH regarding the top 10 homes with high LAS transfers and admissions including presenting conditions to ensure that we pro-actively support patients to prevent ED attendance and avoid admission.

London Borough of Bromley

- Social Workers in Integrated Care Networks (ICN) to proactively support people at risk of decline
- Use of Winter Resilience funding to provide immediate access to 24 hour care at home, additional and enhanced fast response personal care and access to emergency placement where it is not safe for someone to remain at home in order to prevent an admission.
- More intensive community oversight to avoid admissions for vulnerable clients
- Dom-care providers are able to increase the level of care required for urgent & additional care as well as to remain with a client while a contingency plan is put in place to prevent hospital conveyance wherever possible
- Trusted assessor for access to domiciliary care via the Bromley@home service
- Developed policy and process for avoiding emergency admissions via emergency placement for people who attend hospital enabling social attendances to be turned around at the front

- Targeted work with ECH providers including care management staff to identify vulnerable ECH residents, additional health support being provided as part of the MDT to proactively identify vulnerable residence and ensure they have required health input to prevent decline in need and clear expectations of providers on people returning to ECH settings.

Oxleas

- Mental Health Crisis line (24/7) in place for Bromley. This has been developed across Oxleas NHS Trust provision for Bexley, Greenwich and Bromley which is in its infancy will help to support our meeting the needs of individuals who are best served outside of ED, Psychiatric Liaison or the HTT.

St Christopher's

- St Christopher's responds to calls from patients throughout the 24 hour period. I believe St Christopher's staff will be able to refer into and take referrals from the new Bromley@home pilot service, which would avoid a hospital admission.

6.6.3 Ensure timely discharge for medically fit patients requiring ongoing care and support

(e.g. trusted assessor, referring and assessment to community services pre-MSFT to ensure all in place once patient is MSFT, services accessed via single passport document not separate referral form)

King's College Hospital PRUH

- Internal professional standards in place: Board rounds will be performed by 9.30am, Monday to Friday, led by a consultant, registrar or specialty doctor. Expected discharge dates and diagnostics required before discharge will be identified as will referrals to therapies/social services.
- Standardised board round process, tools and training (fully live on growing number of wards at PRUH and Orpington with roll out to all wards by January 2010).
- Regular MADE and Stranded Patient reviews in place.

Bromley Healthcare

- All referrals go through the single point of access ('Care Coordination Centre')
- Support the PRUH with the rehab referral pathway by sending a daily sitrep of accepted patients pending them being MFFD or as required by the ToCB.
- Home Based and Bed Based Rehab Teams are working with our partner agencies to ensure that patients meet the criteria for admission to ensure patient flow continues and also working with partners to try to prevent any unnecessary delays in the pathways. There are daily board rounds to ensure that each patient is reviewed each day

London Borough of Bromley

- Discharge to Assess (D2A) is in place and being mainstreamed across the system
- Additional Extra Care Housing step down units funded through iBCF are now in place to support more people to be discharged to ECH from hospital. Targeted work to ensure the flow through these units is within the required timescale is also being mobilised form October so there are no delays
- LBB has increased general block nursing bed capacity to 70 bed space. Demand mapping has concluded that there will be capacity in the local market over winter 2018/19, with potential to offer providers short-term enhancements if necessary to assure bed space available on discharge.

- Developed joint working of mental health Care Coordinators & hospital Social Workers/ToC Bureau to support discharge for people admitted to the PRUH with mental ill health ensuring equality of discharge support
- St Christopher's Trusted Assessor model in place
- Re-starts available directly from the ward reducing the need for Care Management input improving productivity and timeliness of discharge through direct work with brokerage.
- Additional domiciliary care provision being put in place through procurement from current provider market. The service will include:
    - Packages to start within 2 hours of request
    - No refusals
    - Length of package between 1 or 2 days up to 6 weeks (in 2017/18 average package was 21 days)
    - Single or double handed packages
    - Hospital to provide client information to providers via the 'passport'
    - All work to be delivered during normal working hours 7am to 10pm, BUT service must be available 7 days a week and be prepared to take on new packages at weekend
    - This dedicated capacity will be available from 1st November
- All contracts, including Mission Care and ECH includes 7 day admissions to ensure people can be admitted or return to their place of residence 7 days per week.
- Dedicated work with broader providers to ensure 7 day admission including offer of additional 'resource' to enable this to happen on a weekend

St Christopher's:

- In Reach staff post at the PRUH to facilitate early discharge working alongside D2A team and visiting wards to proactively identify MSFT patients. Ensures knowledge of community teams including capacity is effectively communicated with hospital discharge team and ward staff.

Oxleas:

- Additional psychiatric liaison nurse being put into BH@H which could provide additional capacity in Psych liaison service in the PRUH ED if required.

6.6.4 Maintain people in the community reducing escalation of need

Bromley Healthcare

- The care of all BHC Priority 1 patients are covered within our Business Continuity Plan in case of internal incident, bad weather, extreme staff sickness etc. We run a Health Roster report weekly and archived in case of IT failure to ensure we know which staff are available to enable movement of staff when required. Priority patients schedules are also run and archived in case of an EMIS failure to ensure they are seen.
- We will Pro-actively ensure any at risk patients are referred through the relevant ICN stream including, Proactive Care Pathway and End of Life.
- EMIS BHC/GP shared care records are utilised to obtain up to date clinical information as well as the local Care Record to ensure recent clinical history and information is updated.
- Ensuring that all at risk patients have had a pre-winter care plan review where appropriate.
- Work with the Care Managers and Heart Failure Nurses (from mid-October) attached to the ICN Hubs to support patients at risk over winter. Both specialists can attend the weekly MDT in the DN teams to identify patients at risk of deterioration and support at an early stage.

London Borough of Bromley

- On-going plan to increase reablement capacity to support people to maintain their independence including those who have had a hospital admission
- Contingency plan in the care & support plan of adult carers
- Early intervention service for people with declining needs
- Social Workers now also in the Integrated Care Network (ICN) to proactively manage people with complex health and care needs
- Extra Care Housing (ECH) – tolerance policy (i.e. increase care for up to 2-4 weeks as trusted assessors)
- Targeted plan to ensure all Care and support reviews are up to date by the end of September
- Aim to achieve zero social admissions by:
    - Care Managers working within the Integrated Care Network MDTs
    - Access to emergency placements
    - ASC involvement in Bromley Hospital@home service
    - Avoiding social admissions policy for the hospital
    - Work with domiciliary care providers to report health concerns via 111 *6

Oxleas:

- Additional capacity put into the community 24/7 Home Treatment Team.

St Christopher's:

- St Christopher's Bromley Care Coordination proactively case finds and manages end of life patients so that they can stay in their preferred place of care. St Christopher's record their patients care plans and wishes i.e. DNAR documentation through Coordinate My Care, which LAS can access if the patient go into crisis. As St Christopher's offer a 24/7 advice and visiting service, LAS can redirect patients to their care.

6.6.5 Specific plans to ensure full 7 day service is in place

King's College Hospital PRUH

- Where recruitment / rotas allow services will operate 7 day.

Bromley Healthcare

- Rapid response Team, Rehab services, District Nursing and CCNT are all full 7 day service (accessible from wider trust hospitals for Bromley patients)

London Borough of Bromley

The following operate on a 7-day basis:

- Transfer of Care Bureau (TOCB) Care Managers
- Reablement
- Mental Health Home Treatment Team
- Day centre - Withmore Road
- Dom-care services
- ECH 7 day admission
- Mission Care contract includes 7 day admissions.

    Dedicated work with broader providers to ensure 7 day admission including offer of additional 'resource' to enable this to happen on a weekend

St Christopher's:

Oxleas:

7 APPENDICES:

Appendix 1 – Escalation Contact Information

Appendix 2 – King's College Hospital Foundation Trust Cross Site - Internal Incident Process

Appendix 3 – PRUH ED Department Capacity Management Escalation Policy

Appendix 4 – PRUH ED Capacity Dashboard

Appendix 5 - PRUH- BB UCC Escalation Plan 1819

Appendix 6 - Overall Winter Scheme Spend - CCG-LBB-KCH PRUH

Appendix 7 – KCH PRUH Internal Process for managing repatriations

Appendix 8 – Out of Borough Hospital Referral Process Map

APPENDIX 1

ESCALATION POINT FOR DISCHARGE DELAYS AND ISSUES

Organisation Type	Organisational Name	First Escalation Contact	Second Escalation Contact
Community - rehab	BHC	Head of Rehab	Assistant Director of Operations
Rapid Response	BHC	Service Lead	Assistant Director of Operations
Mental Health	Oxleas	Associate Director - Bromley Directorate	Bromley Services Director
CCG	LB Bromley	Urgent Care lead	AD - Urgent Care and discharge commissioning
Social Services	LB Bromley	Operations Manager - Short Term intervention and Assessment	Head of Assessment & Care Management
No Recourse to Public Funds Team (NRPF)	LB Bromley	Operations Manager - Short Term intervention and Assessment	Head of Assessment & Care Management
Transfer of Care Bureau	LB Bromley	Discharge Team Manager	Transfer of Care Service Manager
Acute Trust	PRUH	Director of Operations	Managing Director of Operations
ECH Contracts	LB Bromley	Commissioning Officer - Programme Delivery	Senior Commissioner - Strategic Commissioning and Business Support
Care Management	LB Bromley	Group Manager Home Care	Operations Manager - Short Term Intervention and Assessment
Equipment	CCG/Bromley	Deputy Head of Contracts	TCES Lead
Brokerage - Package of Care	LB Bromley	Domcare Co-ordinator	Head of Service, Placements & Brokerage
Brokerage - Placement	LB Bromley	Placement Co-ordinator	Head of Service, Placements & Brokerage
St Christopher's	St Christophers	Head of St Christopher's Personal Care Service	Transformation Lead
Urgent Treatment Centre	Greenbrooks	Service Manager	Director of Operations

System Leader for managing surge and response to declaring internal incident:

Managing Director BCCG	CCG
Director of Adult Services	Bromley LA
Director of Commissioning	Bromley LA
Director of Operations	BHC
Chief Executive	BHC
Managing Director	PRUH
Urgent Care Lead	CCG
ToCB Service Manager	PRUH

This page is left intentionally blank

King's College Hospital NHS
NHS Foundation Trust

INTERNAL INCIDENT PLAN AND PROCEDURE

ALL SITES

Document Information			
Version	1.6	Date	March 2018
Ratified by:		King's Executive or Trust Board	
Date ratified:		May 2012	
Author(s):		Peter Martin/Liz Wells	
Responsible Director:		Shelley Dolan	
Responsible committee:		EPRR Working Group	
Date when plan comes into effect:		March 2018	
Review date:		March 2019	
Target Audience:		All Trust Staff	
Location of document:		Trust Intranet - Kwiki or Kingsdocs	

Amendment History

Version	Date	Amendment History	Amendment Authority
1.0	April 2012	New Document	Emergency Preparedness Group.
1.1	April 2013	Annual Review	Emergency Preparedness Group
1.2	January 2014	To reflect divert policy v7	Emergency Preparedness Group
1.3	April 2014	Cross site application	Emergency Preparedness Group
1.4	April 2015	Annual review	Emergency Preparedness Group
1.5	May 2016	Annual review	EPRR WG
1.6	March 2018	Annual review	EPRR WG

Contents

Internal Incident Plan

1. Introduction

Emergency Departments, as public buildings are open public places to which staff, patients and the public have access 24 hours a day. In order to provide a safe environment for staff, patients and visitors it is essential that we address Emergency Preparedness for incidents which require a response which has safety uppermost and ensures continuity of our business.

2. Objective

The Internal Incident Plan seeks to clarify how the Trust responds to a surge or collective number of patients within the Emergency Department which may compromise their safety, and require an advanced and controlled hospital response.

The plan is also suitable to deal with high capacity within the hospital. No two scenarios are alike; therefore, the plan is designed to provide a framework to enable staff to respond flexibly and appropriately to the situation.

The following procedure is to assist the organisation to respond in a co-ordinated uniform manner to ensure the safety of staff, the public and patients under their care and to ensure continuity of business of the Trust.

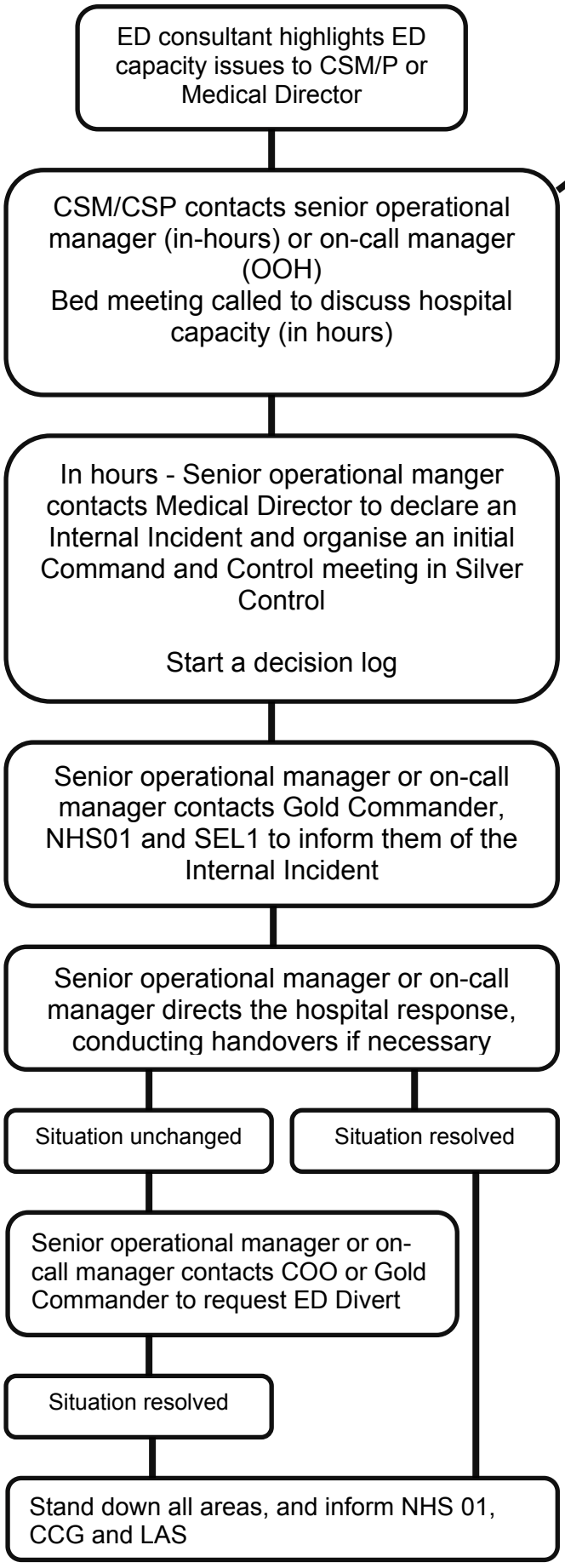
3. Scope of Plan

The Plan will apply without exception to all individuals within the Trust who are employed within or contracted to the Trust

Key personnel who have responsibility in Internal Incident Plan are:

- Nurse In Charge – Emergency Department
- Emergency Department Consultants
- Medical Director
- Site Nurse Practitioner/Manager
- On-call Manager
- Senior Nurses – Emergency Department
- Performance Manager – Emergency Department
- Head Emergency Planning and Clinical Site Management/ Head Nurse Clinical Site Management
- On take Clinical Teams
- Switchboard

4. Internal Incident Flow chart



Internal Incident Cascade

Denmark Hill: Activate Internal Incident call out as per procedure in CSM Office/Silver Grab Bag

PRUH: Switchboard to activate Internal Incident bleep group using pre-determined Internal Incident message

PRUH senior operational manager/Silver Commander to inform Divisional leads on both sites and COO/Dep COO

NHS London: 0844 8222888 and ask for NHS01
CCG Director on-call: 0844 8222888 and ask for SEL1
LAS Control Room: 020 79215197
LAS Senior Clinician on-call:
Page via Control Room

5 Definition

An Internal Incident may be triggered in ED when a surge of patients present over a short period of time, thus causing severe pressure on staff and services to the ED. This increase in volume may jeopardise the safety of patients, and therefore require immediate special arrangements.

It could also be triggered by lack of capacity within the hospital.
There are numerous predisposing triggers; therefore, the plan is designed to provide frameworks to enable staff to respond flexibly and appropriately to the situation.

6 Who can call an Internal Incident*?*

The Internal Incident plan may be initiated by the Senior Operational Manager/On-call Manager, Medical Director, Clinical Site Management/ GEM Divisional Manager. If the issue is in ED the ED Performance Manager/Senior Nurse and ED Consultant should be consulted.

Out of hours the Clinical Site Practitioner/Managershould discuss with the ED Nurse in Charge, ED Consultant, Medical Director and the On-call Manager (Silver) before declaring an internal incident.

7 Exclusions

This document excludes external Major Incident, and Business Continuity issues.

8 Response Team

This team will vary according to the scale of incident but key personnel who must always be informed are:

Office Hours:

- ED Manager/Senior Nurse
- ED Nurse In Charge
- ED Consultants
- Medical Director
- Senior Operational Manager
- CSM/CSP – King's Bleep 333. PRUH Bleep 221
- Nurse in Charge of Medical Admissions Unit
- Switchboard – to inform staff as required by Incident Controller
- Movement of patients and if necessary clean up
    - KCH – Sodexo. Ext 31414
    - PRUH – ISS. Ext 63665/63377

Out of Hours

- Nurse in Charge ED
- On Call ED Consultant/ED Registrar
- On call Medical Director
- CSM/CSP to act as Incident Silver.
- On take Clinical Teams
- Clinical Bleep Holders:
    - KCH – Bleep 320 to cover cardiac arrest. Bleep 293 and/or Bleep 143 to assist Site Nurse Practitioner
    - PRUH - Bleep 319 to cover cardiac arrest. Bleep 224 and/or Bleep 453 to assist Site Nurse Practitioner
- Portering and cleaning
    - KCH – Medirest. Ext 31414
    - PRUH – ISS. Ext 63665/63377
- Security
    - KCH – Bleep 341
    - PRUH –Ext 63291
- On-call Manager (Silver)

9 Outside Agencies

(NB To be contacted on authorisation of the Incident Silver only)

- London Ambulance Service (LAS) 020 7921 5197 Senior Clinical on-call
- NHS England - London 0844 822 2888 Pager NHS01
- South London CCG on call Director 0844 822 2888 Pager SEL 1

10 Incident Control Centre

The Incident Control Centre is located:

- KCH – Operations Centre, Hambleden Wing, Denmark Hill
- PRUH – Clinical Site Office, Trust Headquarters, Level 2, South Wing

11 Preparation

All support departments e.g. pathology, imaging, portering etc in the Trust must have local plans for supporting this incident as described in this document. These plans must be communicated within departments and must be submitted as an appendix to this procedure.

12 Escalation process – capacity issues within ED

- When the numbers in the emergency department are increasing beyond actual capacity or staffing, Nurse in Charge will alert ED Consultant and the CSM/CSP
- Use escalation process to assess situation and discuss if an Internal Incident call is required.

- ED consultant to alert Medical Director.
- CSM/CSP will then discuss with the Senior Operational Manager (out of hours On-call Manager)
- If agreed with On-call manager, the CSM/CSP will request group bleep message an Informer group message "Internal incident" follow your procedures".
- The CSM/CSP then set up the silver control room and follow the appropriate action card.

13 Escalation process – capacity issues within the hospital

- CSM/CSP to discuss with the Senior Operational Manager (out of hours On-call Manager)
- If agreed with Senior Operational Manager/On-call Manager, the CSM/CSP will request a group bleep message and a group message "Internal incident follow your procedures, meeting in Silver Control room at - - - - hrs."
- Switchboard operator will then cascade group call to relevant on call clinical teams with the message "Internal Incident, follow your procedures meeting in Silver Controlroom at - - - - hrs."
- The CSM/CSP will adopt the Incident Controller (Silver) role until relieved by the Senior Operational Manager (in hours) or the On-call Manager (out of hours) and organise the response.
- ED Clinicians will be directed by the ED Consultant and Nursing staff will be directed by the Performance Manager or NIC ED.
- Actions required and response will depend on the situation but patient safety is paramount.
- The Silver commander will contact LAS Duty Officer, NHS 01 and CCG Director on call to make them aware of the situation
- If a Divert is required, the Silver Commander should contact the COO (in hours) or the Gold Commander (out of hours) to provide information required for a divert request
- The Silver Commander should supply a comprehensive clinical assessment of capacity and associated issues to the COO or Gold Commander in preparation for the divert request and subsequent teleconference
- The COO or Gold Commander should follow the instructions in the NHSE Divert Policy V8 if a divert is deemed necessary.
- Once the incident is over Silver is responsible for informing the COO or Gold Commander, NHSE London, CCG and LAS.
- The response team should be told to "stand down" and Silver should ensure that the details of the incident are recorded, a hot debrief should be conducted.

14 Communications

Trust Management - It is the responsibility of the Silver Controller to ensure that the Chief operating Officer (in hours) or the Gold Commander (out of hours) is fully informed and continually updated.

Corporate Communications – Silver Controller should inform Corporate Communications if appropriate to assist with any communications / press enquiries.

15 Reporting and Follow up

The Silver Commander must ensure that Corporate Communications are fully briefed, collect performance reports and ensure outside agencies are informed where necessary i.e. NHSE London, South London CCG, and neighbouring Trusts. A cold debrief should be held and a debrief report of the incident should be completed and submitted to the Chief operating Officer as soon as possible, at least within 14 days of the incident.

ACTION CARD INTERNAL INCIDENT

Incident Controller

Office Hours - Senior Operational manager
Outside Hours - Clinical Site Practitioner/Manager or On-call Manager

Report to Silver Control Room and await the arrival of Response Team.

You will receive brief of the necessary escalation from the Performance manager ED or ED NIC.

1. Assume role of Incident Controller and assume overall command and control of the incident, brief Response Team.
2. In conjunction with the Performance Manager and ED Consultant agree how the incident is to be co-ordinated.
3. Convene a meeting of all Bed managers/Clinical bleep holders in the control room. Request and allocate other available staff to assist the Response Team as necessary for the moving of patients
4. An Incident Control log of actions must be kept of all actions taken including timings for any inquiry.
5. Liaise with the Clinical Site Practitioner/Manager on clinical issues and possible patient movement.
6. If required, declare Internal Incident and follow procedures as in para 9 of this plan
    - For Denmark Hill: Contact Switchboard to activate Internal Incident group and Internal Group bleeps
    - For PRUH: Contact Switchboard to activate Internal Incident group and Internal Group bleeps
7. You will be responsible for issuing the "**stand down**" to the response team. You will remain in the Silver Control Room to debrief the Response Team.
8. All logs must be given to you for compilation of a debrief report.
9. Conduct a Cold debrief and ensure debrief report and any lessons learned are sent to the Head of Emergency Planning.

ACTION CARD INTERNAL INCIDENT

Denmark Hill – Clinical Site Manager (in hours only)

Out of Hours –act as Incident Controller until relieved by Silver Commander– use Incident (Silver) Controller Action Card.

Clinical Bleep Holders on Bleep 293 or Bleep 143 to act as Clinical Site Managers – use Site Nurse Practitioner Card

Report to Silver Control Room

You will receive brief of incident from Incident Controller

1. Instruct Bleep 320 to cover cardiac arrest team calls.

2. Get an update of Trust bed state and inform control room

3. Act as a resource to Incident Controller.

4. With the Performance Manager or NIC ED identify all patients waiting placement, explore options for direct admission and with bed managers/clinical bleep holders allocate beds.

5. If speciality beds not available consider outlying patients at this time.

6. Once patients allocated inform the Incident Control Room for allocation of staff to take patient to ward.

7. Ensure the CMS is up to date and advise Incident Controller.

8. Record a log of all actions for any debriefing after incident.

ACTION CARD INTERNAL INCIDENT

Both Sites KCH - Bed Managers – (in Hours)

Clinical Bleep Holders (out of Hours)

1. Compile most recent bed state within Division and report to the Clinical Site Practitioner/Manager in Silver Control Room
2. Inform Senior Nurse/ Divisional manager that an ED Internal Incident has been declared.
3. In hours put all elective activity on hold and await direction from the CSP/M
4. Follow bed escalation process for ED transfers.
5. Support ED by helping to move patients from ED to allocated wards
6. Record all decisions, requests and actions and give to CSP/M to be included in the incident report.
7. Attend debrief session in the silver Control Room
8. Record all requests and actions and give to CSP/M for inclusion in incident report.

ACTION CARD INTERNAL INCIDENT

PRUH – Clinical Site Practitioner (in hours only)

Out of Hours: act as Incident Controller until relieved by Silver Commander– use Incident (Silver) Controller Action Card.

Report to Silver Control Room

You will receive brief of incident from Incident Controller

1. Instruct Bleep 319 to cover cardiac arrest team calls.

2. Inform Senior Nurse/ Divisional manager that an ED Internal Incident has been declared

3. In hours put all elective activity on hold

4. Follow bed escalation process for ED transfers.

5. Support ED by helping to move patients from ED to allocated wards

6. Get an update of Trust bed state and inform control room

7. Act as a resource to Incident Controller.

8. With the Performance Manager or NIC ED identify all patients waiting placement, explore options for direct admission and with bed Managers/clinical bleep holders allocate beds

9. If speciality beds not available consider outlying patients at this time.

10. Once patients allocated inform Control Room for allocation of staff to take patient to the ward

11. Ensure the CMS is up to date and advise Incident Controller.

12. Record a log of all actions for any debriefing after incident.

This page is left intentionally blank

King's College Hospital NHS
NHS Foundation Trust

Princess Royal University Hospital The Emergency Department Capacity Management Escalation Policy

2018/2019

Emergency Department capacity management escalation document

Document Information			
Version:	1	Date:	June 2017
Ratified by:	Emergency Care Board		
Date ratified:			
Author(s):	Donna Greir, Emergency Department Service Manager Ann Brady Service Manager ED and Acute Medicine (Update September 2018)		
Responsible Director:	Chief Operating Officer		
Responsible committee:	Emergency Care Board		
Date when policy comes into effect:			
Review date:	Annually		
Target Audience:	All Trust staff who are involved in the Emergency Care pathway at PRUH		
Location of document:	Kingsdocs		

Introduction and Purpose

Nationally there is immense pressure on the urgent and emergency care systems, on the achievement of the operational standard for the Emergency Department to achieve the 95% target for all patients to be either admitted, transferred or discharged within 4 hours.

High quality timely care is a desirable requirement for all patients who attend the Emergency Department. With rising volumes of attendances it is an essential part of capacity management to ensure patient journey times are within the 4 hour time span.

The journey through ED varies according to patient need, all steps are outlined but not all are necessary to deliver a complete ED episode of care. Patients attend the Emergency department through walk-in self referral, GP referral or Ambulance referral, patients do not enter the ED from outpatients unless in extreme circumstances. A number of care process steps are undertaken in the emergency departments to ensure safe decision making and admission or discharge decisions can be made

Purpose

The Emergency department escalation process outlines the responsibilities and actions for specified roles in the emergency departments and the associated teams. Escalation assumes additional capacity can be created to manage capacity issues, however this is not always the case and a rapid change in process during extreme measures may also enable additional capacity.

The guideline outlines maximum time spans for periods of patient care in the ED, there are always exception to the rule although these will be minimal they should be escalated for scrutiny and support in patient care and service improvement.

Purpose of Document is to assure all those working in ED are aware of their roles & responsibilities at times of crisis when ED capacity is full or beds are unavailable, hindering flow out of the department.

The process of whom and where escalation should occur is also made explicit

The key principles of the procedure are:

- To support the early identification and mitigation of pressure in the Emergency Department, predominantly arising from unmanaged patient volumes or blocked flow due to bed pressures downstream
- To ensure emerging and real pressures are managed efficiently, with all relevant parties responding at the appropriate time with the appropriate action
- To clearly define role responsibilities, lines of communication and action

The establishment of an effective escalation procedure will contribute to the following:

- Early identification of capacity problems
- Proactive rather than reactive response
- Concise and clear actions
- Defined lines of communication and responsibility

Scope & Exclusions

This procedure will apply to all individuals within the Trust who are involved in providing emergency care for adults and paediatrics with the exception of Maternity services. This procedure covers the configuration and communication of the ED escalation level; it does not cover the processes or procedures required by other directorates to create flow out of ED.

Objectives

The objectives of this procedure are;

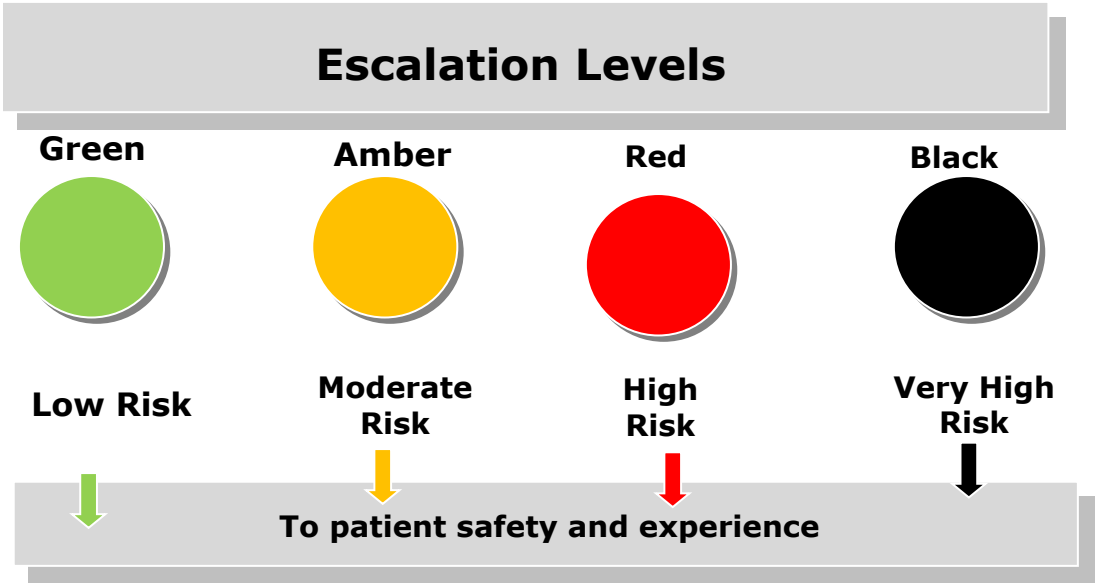
- To optimise patient safety and experience
- To meet nationally agreed clinical quality indicators for emergency care
- To ensure that patients attending the ED:
    - have an initial clinical assessment within 15 minutes
    - have a timely start to full clinical assessment with a medium time of less than 60 minutes from time of arrival
    - if referred to an admitting team for assessment are seen and have a plan in place within 60 minutes of referral
    - are treated and discharged or admitted within a 4 hour period.

Emergency Department Escalation Levels

The following escalation levels will be used to help communicate the escalation status and guide people to the correct actions. This is based on a colour scale that reflects the level of risk to patient safety and the extent to which patient experience may be compromised.

The ED NIC will inform the ED Manager or the Silver Back-up manager of the escalation level in order for appropriate action to be taken.

The Emergency Department white board located in Majors B opposite NIC desk will display the escalation level of the department.



OVERALL EMERGENCY DEPARTMENT STATUS

Green	Department is running well, with no concerns
Amber	Early indication that issues are arising, but standard operational responses should provide resolution (< 3 triggers, internal ED escalation / safety huddle)
Red	Significant concerns that will require out of the ordinary reactions (3 or more triggers to be escalated to Trust senior team
Black	Patient safety is at risk, and becomes the focus of the department ((Silver to escalate to Gold control

ED Actions in Escalation

A number of actions have been identified to ensure patient safety and flows are returned to an optimum state as quickly as possible and to allow de-escalation to 'Green'. In order for successful de-escalation it is crucial that all actions are carried out by the relevant members of Trust

ED Trigger	Escalation Trigger	Amber	Red	Black
Ambulance Offload post triage	**3 or 30 mins**	Ambulance escalation plan in place in the department.		
Total Number of patients in the department	**35, 45 & 55**	**35 patients.** At each huddle this will be discussed and plans put in place for all patients over 2 hours. The patients awaiting movement out of the department will be discussed with the CSM Team	**45 Patients** As Amber and the senior Team will be informed at the next Bed Meeting	**55 Patients** As Red and the senior leadership team will be informed directly in hours and Silver on call Out of Hours
Surge of patients in the last hour	**10, 15, 20**	**10** At each huddle this will be discussed and plans put in place surge of attendances in the last 3 hours and plans in place to ensure no increase in wait in the department.	**15** As Amber but noting any increase in delays to be triaged both LAS and Walk in. Escalated to NIC who will discuss at Huddle	**20** As Red but also escalation to CSP team to be escalated to Senior Leadership team to ensure awareness is maintained and planning can start for potential increase in the need for beds in the next 2 hours
Waiting time for Clinician	**>1 hour 45 mins**	**>1 hour 45 mins** EPIC and NIC to liaise and discuss with medical team ensuring all doctors are supported un making timely decisions and management plans.	**>2 hours 15 minutes** As Amber but discuss in the huddle if occurring or discuss with CSP team out of huddle time to ensure they are aware of wait times	**>3 hours** As Red but Liaison with
Waiting time for speciality post referral	**>60 mins**	Escalated as per each speciality process	As Amber plus escalation to CSP Team	As per Red including escalation to the Senior Leadership Team

Waiting Time for Diagnostics	**20 minutes for plain film x-ray** **Any delay for CT** **60 minute turnaround time for routine ED blood tests**	At each huddle this will be discussed and escalated to CSP Team	As Amber but discussed by the service management team with the SM for radiology Bloods: As Amber but discussed by the service management team with the Labs	As Red but escalated to the GM for Radiology by the SM Team Bloods: As Red but discussed with the senior leadership team
Available Cubicles	**Less than 3**	**Less than 3** Discussed at the safety huddle regarding how capacity can be maintained. Doubling up and boarding (as per policy) will be discussed when availability is less than 3 and no movement is planned imminently	**Less the 2** As Amber but escalate to the CSM Team regarding capacity capability	**Less than 1 or 0** As Red but escalation to the senior team for potential escalation to the Surge Hub
Patients in Resus	**4**	Discussion with doctor in charge of Resus and the EPIC to potentially step down a Resus patient to ensure capacity can be maintained. Triage nurse will also implement Blue call triage	**4+1** As Amber but also escalation to the CSM team regarding capacity issues	**4+2 or higher** As Red but escalation to the senior team for potential escalation to the Surge Hub
Patients > 12 hours in dept, both Mental Health and Medical	**3**	See Mental Health pathway and patients with DTA's will be discussed with CSM Team and planning put in place Medical/ Surgical Patients to be escalated to the CSM team.	>13 Hours As Amber but the escalation should now be to the Senior Leadership Team for dissemination to all CD's and GM's	>14 Hours As Red but all escalation should be to the Senior Leadership team for potential declaration of internal incident due to capacity issues
Number of DTA's	**5**	**5** Discussed at safety huddle to put in place a plan for all DTA's including mapping into discharges	**8** As Amber but also escalation to the CSM team regarding capacity issues	**12** As Red but escalation to the senior team for potential escalation to the Surge Hub
Number of Beds in CDU	**1**	EPIC and CDU Consultant discussion regarding plans for CDU patients and if any discharges / movement can be expedited	As Amber but with escalation to the CSM team to highlight capacity issues in CDU	As Red but escalation to the Senior Leadership Team highlighting capacity issues in CDU

Number of Outliers in CDU	**>3**	Discussion in the safety huddle with the CSM team and with the Acute Physician regarding review and planning for these patients	As Amber but with escalation to the CSM team to highlight capacity issues in CDU	As Red but escalation to the Senior Leadership Team highlighting capacity issues in CDU

Communication Flow

	Green	**Amber**	**Red**	**Black**
In Hours Monday – Friday 8am-5pm	ED NIC to ED EPIC	ED NIC to ED EPIC ED NIC to ED SM ED SM to CSP Team	ED NIC to ED EPIC ED NIC to ED SM ED SM to CSP Team	ED NIC to ED EPIC ED NIC to ED SM ED SM to CSP Team CSP/ SM to PRUH Senior Management Team PRUH Senior Management Team to KE
Out Of Hours	ED NIC to ED EPIC/ Senior Doctor	ED NIC to ED EPIC/ Senior Doctor ED NIC to CSP Team	ED NIC to ED EPIC/ Senior Doctor ED NIC to CSP Team CSP to PRUH Silver on Call	ED NIC to ED EPIC/ Senior Doctor ED NIC to CSP Team CSP to PRUH Silver on Call PRUH Silver on Call to Trust Gold

3.3 Escalation of potential 12 hour trolley breaches

Trigger Points	6 Hours from DTA (green)	8 Hours from DTA (amber)	10 Hours from DTA (red)	At 12 hours (black)
A 12 hour trolley breach is recorded if a patient remains in the department 12 hours after the decision to admit (DTA) has been declared	CSM Team discussion in huddles/ bed meetings regarding planning of movement of these patients from the department Ensure the patient and their families are kept informed of the situation and updated with any changes.	Senior Leadership team informed and discussion at bed meeting regarding planning for placement of patients External escalation to the surge hub may be implemented if there is a real risk of 12 hour breaches Ensure the patient and their families are kept informed of the situation and updated with any changes.	Senior Leadership Team/ Silver on call to be informed of the position in the department. Escalation by the senior team/ silver on call to Gold will occur. External escalation to the surge hub/ CCG on call regarding the situation within the department Ensure the patient and their families are kept informed of the situation and updated with any changes.	Senior Leadership team/ Silver on call to be immediately informed Escalation by the senior team/ silver on call to Gold will occur. External escalation to the surge hub/ CCG on call regarding the situation within the department Ensure the patient and their families are kept informed of the situation and updated with any changes. Service Manager to complete the 12 hour RCA and send to the senior leadership team, once signed off ensure it is sent to the Surge Hub.

Appendix 1

Action Cards

ED Nurse in Charge – ED escalation actions

Patient safety and quality of care is to be maintained at all times – identify any risks to patient safety or quality of care and escalate these immediately to ED Service Manager / Matron / OOH Back-up manager

GREEN	- Manage ED department in accordance with ED NIC role - Review staffing levels for the shift and next 24 hours to identify any gaps in rota - Monitor activity and potential incoming demand - Inform EPIC of any change in volume / acuity of incoming patients - Pre-empt beds and request as early as possible - Transfer all patients out of ED within 15 minutes of bed allocation - keep Symphony updated with clear plans for any patient over 3 hours - Identify and escalate any emerging issues which could impact capacity and flow
AMBER	- Review allocation of staff and relocate nursing staff to areas of high demand - NIC and EPIC to do mini board round, Rapid review' of patient conditions, dept capacity and escalation actions - Attend Safety Huddles - Inform ED Service manager of number of patients requiring transfer out of ED - Hand over all staffing issues to ED matron for escalation to senior team and prioritise coordinatation of ED
RED	- Green & Amber actions to continue - Follow triggers on escalation policy - Attend Safety huddles - Patient safety and quality of care is to be maintained at all times – identify any risks to patient safety and escalate these immediately - Escalate any safety concerns with EPIC and ED service manager - All staff available to support the ED shop floor to maintain safety
BLACK	- All actions above to be completed - Escalate to senior leadership team for escalation to Trust Gold - Attend Safety Huddles for local escalation.

ED Physician in Charge (EPIC) – ED escalation actions

Patient safety and quality of care is to be maintained at all times – identify any risks to patient safety or quality of care and escalate these immediately to ED Service Manager / Matron / OOH Back-up manager

GREEN	- Communicate clearly with NIC regarding flow of patients and potential issues - Manage ED department in accordance with ED medical coordinator role description
AMBER	- Review allocation of staff and relocate medical staff to areas of high demand / sub-acute area - Decant patients out of high demand areas of ED to accommodate incoming patients where safe to do so - 'Review actions taken and jointly agree additional actions with NIC - Attend ED safety huddles to expedite escalation
RED	- Green, Amber actions to continue - Increase if possible the number of doctors on shop floor Patient safety and quality of care is to be maintained at all times – identify any risks to patient safety and escalate these immediately - Attend Safety Huddles - All staff available to support the ED shop floor to maintain safety - EPIC to stream patients direct to specialties
BLACK	- All actions above to be completed - In conjunction with site Silver liaise with trust Gold to plan for the next hours in the department

ED Service Manager – ED escalation actions

Patient safety and quality of care is to be maintained at all times – identify any risks to patient safety or quality of care and escalate these immediately to ED Manager / Matron / OOH Back-up manager

GREEN	- Visit ED / CDU at the start of the shift and ascertain current situation - Attend All ED safety huddles in hours - Communicate regularly with CSM to ascertain current bed capacity and any emerging issues on AMU - Regularly review Symphony and obtain updates from NIC to understand current status of department
AMBER	- Liaise with NIC and EPIC to ensure all necessary actions are underway (refer to their action cards) - Support NIC and EPIC with the flow of department - Notify CSM and Senior Leadership team if any change in status occurs - Identify reasons for amber status - Review actions undertaken by ED department NIC and liaise with Matron - Contact LAS and inform them of capacity constraints in the department - Attend all ED safety huddles - Identify specialties who have more than 2 patients waiting and request additional support from specialties - Review of any delays with diagnostics - Review that IPS targets are being met, ie 1 hour wait for specialty decision - Look outside of ED for additional support – porters, nursing staff - Liaise with Therapy services and TOC to support ED discharges - Work with site team to transfer patients out of CDU into specialty wards or discharge appropriate to increase CDU capacity
RED	- Amber actions to continue - Escalate immediately Senior leadership team/ Silver on call with clear reasons for the change in escalation to red with clear explanation of actions taken - Review effectiveness of amber actions and agree additional actions to be taken - All staff available to support the ED shop floor to maintain safety
BLACK	- All actions above to be completed - Take instruction from Senior leadership team/ silver on call.

Appendix 2

Princess Royal University Hospital Emergency Department
Emergency Physician in Charge
(EPIC)

Introduction

The Emergency Physician in Charge (EPIC) role is undertaken predominantly by a trained Emergency Medicine consultant. It can also be undertaken by a substantive ED Senior (ST4 equivalent or above) although supervision and training may be required for this to occur safely.
The key aims of this role are to –

- Provide senior medical leadership to the ED.
- Ensure safe, effective care for all ED patients.
- Support the staff in the ED environment.
- Meet the 4-hour Emergency performance standard.

Location/Contact

- The main "base" for the EPIC will be in Majors B. However, there is an expectation that the EPIC will be mobile throughout the shift supporting the various areas as required.
- To facilitate this, the EPIC will carry the wireless phone (ext.63722).

Key Relationships

- Overall Nurse in Charge of ED (ONIC).
- ED Matron.
- Other clinical ED consultants.
- Majors A& B Nursing Co-ordinators.
- CDU Nurse in Charge (re capacity).

Responsibilities

Patient Contact / Patient Safety

- The key to a successful EPIC is situational awareness of the whole ED - "command and control". This cannot be achieved if the EPIC sees patients fully. However quick cases or streaming can be possible within this role.
- Oversight and/or assistance of all critically ill patients in Resus, or elsewhere, should be undertaken (unless Resus consultant present).

- Waiting patients categorised as “T2” (very urgent) should be allocated to a doctor as soon as possible. Otherwise the EPIC should attend and perform immediate measures pending a doctor being available.

Run handover

- Leading the 0800hrs handover in ED seminar room. Also, subsequent handovers to 1600hrs EPIC or night shift Senior in Majors B.
- Should include handover of patients in ED/CDU, critically ill patients still in ED, significant issues of last shift & staffing.
- May also include short 3-minute teaching (*“thought for the day”*)

Staff Management

- Allocation of medical staff to different areas of the department. This will be fluid and responsive to the demands of various ED areas. It may deviate from the doctors’ pre-written team allocation.
- Follow up on any doctors off sick or late and ensure cover for current and subsequent shifts is adequate.
- Ensure that doctors get breaks at appropriate times.
- Induction of new locum doctors. This should include tour of the ED, IT systems induction and written PRUH ED information if not already supplied by the locum agency (may be delegated).
- Ensure that RAT and Subacute are operational for as long as possible where staffing allows.

Senior Decision Maker/Advisor

- The EPIC should be the focus of clinical questions from the junior doctors, nurses and UCC staff.
- This will also include ECG or Blood gas “sign-off” if performed before doctor assessment.
- The EPIC should also be the key senior decision maker for the junior doctors. This will be pro-active as well as reactive – finding the relevant juniors after their assessment, ensuring that plans are formulated and early referrals made if required. This may involve EPIC review of the patient or advice alone and is case dependent.
- Some of the above work can be undertaken by ED consultants allocated to other areas (e.g. Paeds/Resus, Subacute).

Symphony

- Ensure that the medical aspects of Symphony such as referrals and discharges are kept up to date.
- Aim to enter breach reasons in real time as they occur.

Flow & Capacity Management

- In partnership with the ONIC, aim to safely achieve the 4-hour performance standard.
- Also with the ONIC, make sure that cubicles are used as efficiently as possible. If necessary admitting patients to wards, CDU (as per relevant CDU pathway) or transferring them to the waiting room to make space.
- Liaise with ED Resus staff to ensure timely “step-down” or admission occurs to allow capacity.

- Ensure all available space is being used at times of crisis (e.g. Plaster Room, Subacute, UCC etc.)
- Look at alternatives to ED assessment (e.g. Ambulatory Clinic).
- Participate in “safety huddles” with ONIC.

Streaming / “ad hoc RAT”

- Outside of RAT doctor hours, order investigations, analgesia etc. if time allows.
- Stream GP letter referrals for in-patient specialties if appropriate.
- Liaise with Medical Ambulatory Clinic on selected GP letter referrals or other appropriate ED patients.

ED Enabler

- EPIC to act as arbitrator if disagreement on referrals/admission as per the Internal Professional Standards.
- To escalate or intervene if significant delays to in-patient team response times.

Self-Assessment Tool

- Could you hand over the Symphony screen of patients if asked?
- Have plans been formulated for those patients?

References –

1. Plymouth Hospitals NHS Trust Medical Controllers SOP
   http://www.rcemfoamed.co.uk/wp-content/uploads/2014/12/Fat-controller-SOP.pdf
2. Kings College Hospital NHS Foundation Trust PRUH ED Overall Nurse in Charge SOP

Author –

Mitesh Davda
ED Consultant 09/11/2016
Final Version 1.0

Emergency Department

Overall Nurse in Charge.

Introduction

The overall nurse in charge (ONIC) role will usually be undertaken by a band 7 sister/charge nurse (or experienced 6), and is a multi-faceted role that requires the nurse to take a 'global' view of the department. The ONIC will move around the whole department supporting the different clinical areas as required.

The ONIC will 'champion' the patient experience in ED by paying particular attention to safety and monitoring patient flows promoting the clinical standard of the 4 hour target, the patient environment, care standards, monitor staffing levels for next 24 hours, supporting decision making and support patient access to appropriate care pathways.

In particular the ONIC will:

Patient safety

- Monitor nursing care across the department addressing shortfalls as they occur and escalate any concerns not able to resolve.
- Monitor the available capacity and escalate timely to Site Team to ensure the department's ability to deliver safe and timely care.
- Respond professionally and timely to patients concerns and complaints, actively seeking to resolve issues at the time
- Ensure '*shift check lists'* and shift reports are completed & submitted.
- Ensure DATIX are completed for all incidents and near misses and actively encourage a safety aware culture.
- Participate in '*safety huddles*'.

Staff Management

- Check the allocation book against the off duty for the next 3 shifts paying particular attention to the next 24 hours, covering shortfalls of staff.
- Book bank/agency as required and escalate shortfalls to matron.

- Ensure *'Return to Work interviews'* are undertaken on any staff returning to work following sickness absence
- Allocate staff to areas of the department according to staff skills and patient needs and/or safety. **The staffing allocation is not static and will need revaluation throughout the shift, moving staff to deal with fluctuation of demand**.
- Oversee staff breaks, ensuring that safe and adequate staffing levels are maintained while breaks are being taken. Overlapping of break times within areas of the department is not permitted.

Patient environment

- Continually monitor the patient environment directing both ED and ISS staff to address shortfalls; if non compliance; escalate as appropriate. For all infrastructure issues, the Site Team should be made aware.
- Ensure that '*daily check lists'* are completed in all areas of the department.
- Ensure there is sufficient stock and supplies are available to facilitate timely care, including pharmacy, MSSE, CSSD, linen and pillows
- Liaise with and direct the ED support worker/house keeper.

Patient Flows

- Liaise directly with the EPIC on duty to ensure/request that medical staff are correctly allocated or moved to appropriately manage patient safety, timely flow and care needs demand.
- Liaise with the Site Team to promote a 2 hourly advanced look at demand in ED, promoting and chasing plans for patients.
- Monitor the patient timeliness across the department and escalate when and to who necessary.
- Ensure requests for beds are made timely to the appropriate Site Lead.
- Inform the Senior Site Practitioner when available capacity becomes limited. (ie one resus space, 4 or less cubicle spaces) and ensures transfers out of ED occur as soon as possible when beds available.
- Actively encourage the use of Ambulatory care and suggest patients if not yet identified by EPIC/ doctor role.
- Actively seek to meet ambulance turn around times and promote smooth transitions where ever able.
- Assist in creating a culture of adherence to safely meeting government targets and best practices.

- Monitor the capacity and escalate issues which will impact on the department's ability to delivery timely care prior to the issue being created wherever possible
- Promote the use of Nurseless transfers wherever clinically safe to do so.

Patient access to correct pathways

- The ONIC will have a broad knowledge of alternatives to admission, using department written resources where necessary. The ONIC will seek alternatives to an admission as appropriate for the patient.
- The ONIC will liaise directly with the multi agencies i.e. Social Services, GP, District Nurse to facilitate safe discharge of patient and when possible alternatives to admission to hospital.
- The ONIC may attend bed meetings as required.
- Escalation of waiting times and potential breaches should be identified at the earliest opportunity. This includes ambulance off loading times over **15** minutes and/or two ambulances awaiting to off load. The Senior Site Practitioner must be informed.
- If ambulance off load times are likely to exceed 30 mins then immediate escalation to the Senior Clinical Site Practitioner must occur who will also escalate as appropriate but who will liaise with the appropriate Ambulance Service and ensure plans to resolve asap are put in place.

ED Bronze – role & responsibility

Overview

The role of the ED Service Manager is fundamentally important to the management support infrastructure of the department.
Working closely in conjunction with the lead clinicians and NIC of each area, the ED Bronze manager is responsible for managing flow and escalating issues as they arise.
In addition, the ED Bronze manager works closely with the CSM to manage timely outflow of patients from the department and monitor specialty compliance with the internal professional standards.

Key Responsibilities

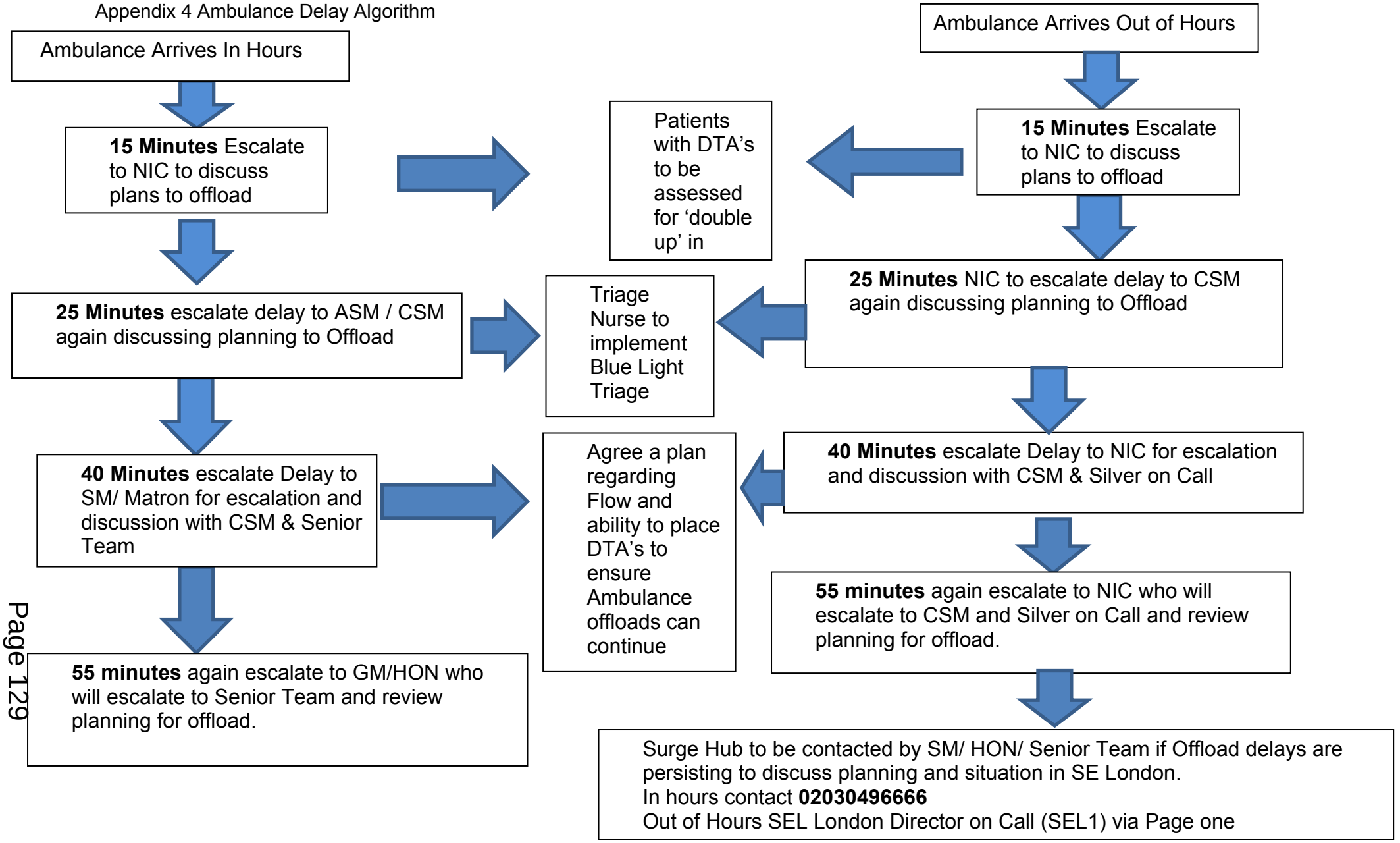
The NIC of each area is responsible for escalating to the ED Bronze manager any delays in the patient's pathway or issues with specialty interface.
The ED Bronze manager must:

- Ensure clear overview of department at all times.
- Ensure overview of HAS and ambulance turnaround times
- Be aware of all pts referred to specialties and time of referral, escalating delays as per protocol.
- Escalate to CSM all pts waiting over 4hrs for bed.
- Monitor surges in activity and potential impact on clinical teams, working with the ED clinicians to identify pts who can step down if required.
- Monitor surges in LAS activity.
- Work closely with the NIC of each area to ensure all 4hr breaches are labelled in real time and that symphony is kept up to date.
- In liaison with the clinical site practitioner, ensure that CMS (Capacity Management System) is updated every 3hours
- The ED Bronze manager should attend Ed safety Huddles.
- Escalate wait for specialty if patients waiting 1 hrs for specialty review and management plan Escalate according to specialty triggers TBC
- If the outcome of the ED status board indicates that the department is at capacity and clinically unsafe escalation to CSM (in hrs) and silver on call (OOH)

Escalation Levels

GREEN	AMBER	RED
Department functioning well Indicators of safe department include: • Less than **35** patients in the Department • Resus has **2** spaces, • Majors A&B have >3cubicles • Triage time is less than 15 minutes. • All patients are seen within 60 mins by a Senior clinical decision maker. • 1 Male, 1 Female bed empty in the CDU • Less than 15 minute delays in off-loading Ambulances • Staffing levels for nurses or doctors at appropriate levels • 95% of patients discharged within 4hours **Action Required** • Step delays to be monitored for any deterioration • ED safety huddles over the whole 24 hour period • Staff to be moved to accommodate changes in activity levels • Speciality Referrals to be escalated as per plan • Maintain constant and effective patient flow	**If 3 or more of the following are reported** • Between **35** and **45** patients in the department • Time waiting to be seen in excess of 2 hours 15 minutes. • Any speciality patient waiting more than 30mins from referral. • More than 30 patients have arrived in under 3 hours • Less than two cubicles in Majors A&B • 1 Resus space left. • 5 or more patients awaiting bed allocation greater than 30 mins from DTA • One 30 minute breach or more in off-loading an Ambulance in the last hour • ED Staffing levels 1 doctor down or more than 2 nurses down on baseline • Delays from request of over 30 minutes in X-ray • >60 minutes turnaround on blood results. • 92-95% of patients discharged within 4 hours **Action Required** • ED Matron / CSM made aware in the ED safety huddles • Any speciality delays follow escalation process. • Discussed at safety huddle to put in place a plan for all DTA's including mapping into discharges • EPIC and CDU Consultant discussion regarding plans for CDU patients and if any discharges / movement can be expedited	**If 2 or more of the following are reported** • More than **45** patients in the department • More than **45** patients have arrived within 3 succesive hours • No resus space • 2 ED doctors down or 4 ED nurses down over baseline • 2 or more 60 minute ambulance breaches in last 2 hours • Less than 92% of patients discharged within 4hours **Action Required** • EPIC and CDU Consultant discussion regarding plans for CDU patients and if any discharges / movement can be expedited • As Amber but also escalation to the CSM team regarding capacity issues • Patients in the department >12 hours escalation should now be to the Senior Leadership Team for dissemination to all CD's and GM's **If 3 or more of the above are reported this would trigger a Black Alert** **BLACK** • SM to contact Silver who should inform Gold of potential Critical Incident. • Prepare for Black Alert – Critical Incident

Appendix 4 Ambulance Delay Algorithm



This page is left intentionally blank

BIU Business Intelligence Unit

Full Capacity Dashboard

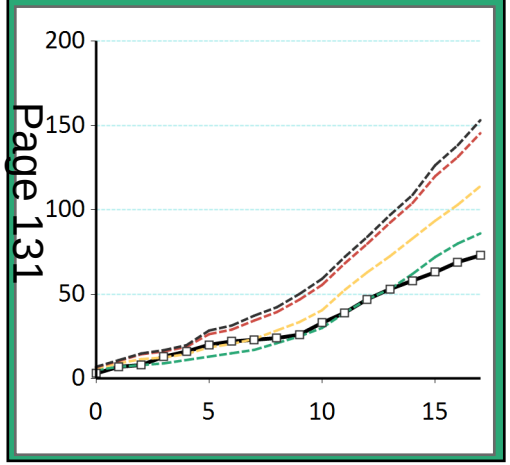
v.1.13

PRUH ED OPEL 1

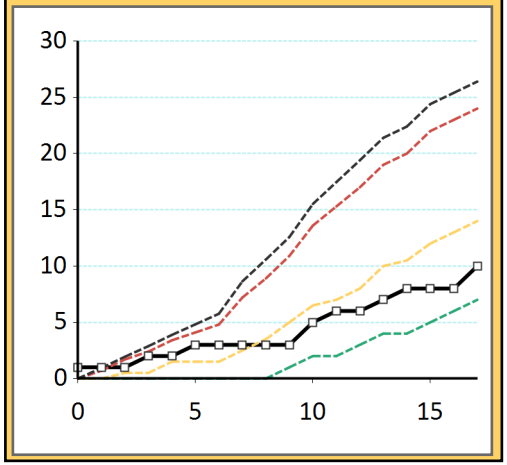
King's C

MAJORS		RESUS		PAEDS		UCC	
OPEL	# IN DEPT.	OPEL	# CUBICLES OCC.	OPEL	# IN DEPT.	OPEL	# IN DEPT.
2	30	1	4	1	11	0	5
# WAIT BED	# WAIT 1ST CLIN.	# WAIT BED	# WAIT 1ST CLIN.	# WAIT BED	# WAIT 1ST CLIN.	# WAIT BED	# WAIT 1ST CLIN.
5	2	2	0	0	5	0	0
# WITH SPEC.	ARR.SINCE 00:00	# WITH SPEC.	ARR.SINCE 00:00	# WITH SPEC.	ARR.SINCE 00:00	# WITH SPEC.	ARR.SINCE 00:00
21	77	4	10	2	33	1	24

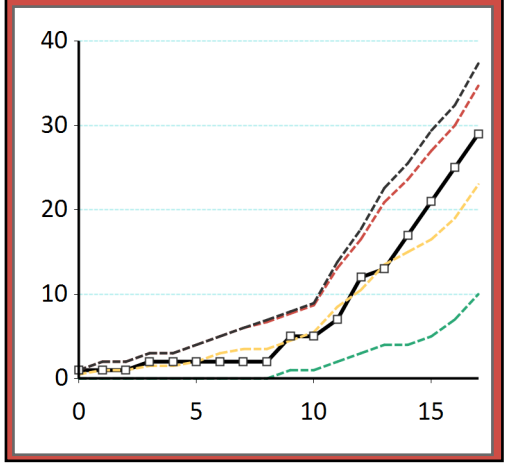
CUMULATIVE MAJORS



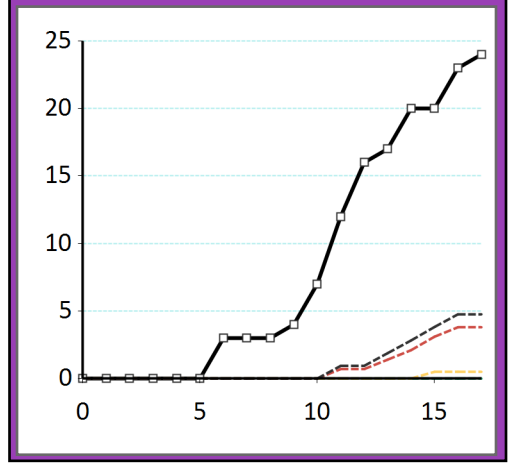
CUMULATIVE RESUS



CUMULATIVE PAEDS



CUMULATIVE UCC



BIU Business Intelligence Unit

Full Capacity Dashboard

v.1.13

PRUH ED OPEL 1

King's C

WAITS (MINUTES)	
MAX WAIT TRIAGE MAJORS	183
MAX WAIT TRIAGE PAEDS	40
MEDIAN WAIT 1ST CLIN. MAJORS	15
MEDIAN WAIT 1ST CLIN. PAEDS	52
MEDIAN WAIT 1ST CLIN. UCC	
MED. WAIT WITH SPEC (EX.S.S.)	107
# WITH SELECTIVE SPEC.	4

BIU Business Intelligence Unit

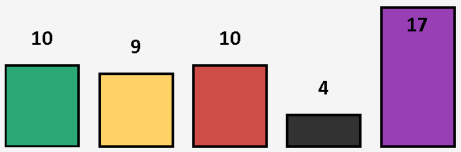
Full Capacity Dashboard

v.1.13

PRUH ED OPEL 1

King's C

PATS. IN DEPT.	MAJORS >75yrs	# WAIT ADULT TRI.	# WAIT PAED TRI.		PATIENTS IN >= 12H	PATIENTS IN >= 24H
50	11	4	3		0	0



Full Capacity Dashboard

v.1.13

PRUH ED **OPEL 1**

King's C

Created by
Hardik Korat
Anil Parmar
Dominic Thurgood
King's College Hospital
Business Intelligence
Unit

ACTIVITY ESCALTION PLAN – PRUH UCC

To determine status column 1 plus one other should apply

Between 07:00 and 22:00 Monday to Friday

RAG Status	Number of patients in the UCC 1	Rapid Assessment Time for Children 2	Streaming time for adults 3	Time to treatment 4	Other 5	Action
Green	Up to 30	15 minutes or under	Less than 20 Minutes	Below 2 hours		No Action required
Amber	Between 30 and 35	More than 15 minutes	More than 20 minutes	Over 2 hours	15 or more patients booked in over a one hour period	Amber Action required
Red	Exceeds 35	More than 15 minutes	More than 30 minutes	Over 3 hours	15 or more patients book in over a one hour period for two consecutive hours	RED Action required

Between 07:00 and 22:00 Saturday and Sunday

RAG Status	Number of patients in the UCC 1	Rapid Assessment Time for Children 2	Streaming time for adults 3	Time to treatment 4	Other 5	Action
Green	Up to 35	Under 15 minutes	Less than 20 minutes	Below 2 hours		No Action Required
Amber	Between 35 and 40 patients	More than 15 minutes	More than 20 minutes	Over 2 hours	20 Patients or more book in over a one hour period	Amber Action required
Red	Exceeds 40	More than 15 minutes	More than 30 minutes	Over 3 hours	20 patients or more book in over a one hour period for two consecutive hours	RED Action Required

See over for Night Escalation Plan

Between 22:00 and 07:00

RAG Status	Number of patients in the UCC 1	Rapid Assessment Time for Children 2	Streaming time for adults 3	Time to treatment 4	Other 5	Action
Green	Up to 20	Under 15 minutes	Less than 20 minutes	Below 2 hours		No Action Required
Amber	Between 20 and 25 patients	More than 15 minutes	More than 20 minutes	Over 2 hours	10 Patients or more book in over a one hour period	Amber Action required
Red	Exceeds 25	More than 15 minutes	More than 30 minutes	Over 3 hours	10 patients or more book in over a one hour period for two consecutive hours	RED Action Required

Appropriate Escalation is crucial to the safe management of the UCC. The lead nurse should ensure she is aware if the status of the department at all times and complete a Sitrep if the department is not in a Green position.

Actions should be followed and documented on the sitrep form.

ACTIVITY ESCALTION PLAN – BB UCC

Between 08:00 and 21:00 Tuesday to Friday

RAG Status	Number of patients in the UCC	Rapid Assessment Time for Children	Streaming time for adults	Time to treatment	Other	Action
Green	Up to 20	15 minutes or under	20 Minutes or under	Below 2 hours		No Action required
Amber	Between 20-25	More than 15 minutes	More than 20 minutes	Over 2 hours	15 or more patients booked in over a one hour period	Amber Action required
Red	Exceeds 25	More than 15 minutes	More than 30 minutes	Over 3 hours	15 or more patients book in over a one hour period for two consecutive hours	RED Action required

Between 08:00 and 21:00 Saturday to Monday

3 or more triggers in any section will activate either amber or red status

RAG Status	Number of patients in the UCC	Rapid Assessment Time for Children	Streaming time for adults	Time to Treatment	Other	Action
Green	Up to 25	15 Minutes or under	20 minutes or under	Below 2 hours		No Action Required
Amber	Between 25 and 30 patients	More than 15 minutes	More than 20 minutes	Over 2 hours	20 Patients or more book in over a one hour period	Amber Action required
Red	Exceeds 30	More than 15 minutes	More than 30 minutes	Over 3 hours	20 patients or more book in over a one hour period for two consecutive hours	RED Action Required

Amber Actions:

The Shift Lead Nurse to assess the workload and capacity and ensure that the workforce is distributed to deal with the demand

The Nurse Shift Lead to consider immediate actions:

1. Moving additional ENP/GP to streaming
2. GP's to assist with injuries
3. ENPs to assist with illnesses: initial assessments, observations and urine dips to support GP's
4. Eye ball the waiting room: identify patients who may be deteriorating, needing analgesia, repeat observations when needed etc.
5. Ensure patients are being sent for X-ray at triage when appropriate
6. Assess the ENP off duty and the GP rota and establish if staffing levels are sufficient to deal with the current situation.
7. Look at the possibility of extending the working hours of the GPs/ENPs if necessary
8. Must inform the waiting room of the delay being as accurate as possible with waiting times.
9. Patient Champion / Receptionist to use all available Hub appointments

The Shift Lead Nurse must brief the GPs, reception staff and the streaming nurse that their treatment time **is over 2 hours** and that patients will be prioritised depending on their presenting complaint.

In hours - The shift Lead Nurse must inform the UCC Service Manager (or deputy) on site.

Out of hours – If the issues cannot be resolved the UCC on-call Manager should be informed and Sitrep form should be completed and handed over so that a decision can be made.

Drinking water must be available at all times in the UCC. If patients wish to leave the department to go to the restaurant/coffee shop this should be permitted advising approximately how soon they should return.

The safety of the waiting patients is paramount and observation of the waiting room should be on going throughout the shift.

ESCALATION PLAN – ACTION CARD

Red Actions:

If the volume of patients triggers the red escalation plan, the Shift Lead Nurse to assess the workload and capacity and ensure that the workforce is distributed to deal with the demand.

The Nurse Shift Lead to consider immediate actions:

1. Moving additional ENP/GP to streaming
2. GP's to assist with injuries
3. ENPs to assist with illnesses: initial assessments, observations and urine dips to support GP's
4. Eye ball the waiting room: identify patients who may be deteriorating, needing analgesia, repeat observations when needed etc.
5. Ensure patients are being sent for X-ray at triage when appropriate
6. Assess the ENP off duty and the GP rota and establish if staffing levels are sufficient to deal with the current situation.
7. Look at the possibility of extending the working hours of the GPs/ENPs if necessary
8. Must inform the waiting room of the delay being as accurate as possible with waiting times.
9. Consider see & treat for minor injuries and minor illnesses.
10. The ED Shift Lead should be informed that the UCC is in Red escalation.
11. Patient Champion / Receptionist to use all available Hub appointments

The Shift Lead Nurse must brief the GPs, reception staff and the streaming nurse that their treatment time **is over 3 hours** and that patients will be prioritised depending on their presenting complaint.

In hours: The shift Lead Nurse should assess the staffing levels and discuss with the UCC Service Manager.

Out of hours: The UCC Service Manager should be informed if the situation is not resolving within 90 minutes.

Drinking water must be available at all times in the UCC. If patients wish to leave the department to go to the restaurant/coffee shop this should be permitted advising approximately how soon they should return.

The safety of the waiting patients is paramount and observation of the waiting room should be on going throughout the shift.

Management and Reception staff can be redeployed to undertake other tasks within their capability where necessary.

This page is left intentionally blank

Commissioning organisation	Organisation	Scheme Title	Scheme Description	Cost	Expected Impact
Bromley CCG	Bromley Health Care/ BGPA/ St Christopher's	Bromley Hospital @ Home	Integration of existing health and social care admission avoidance provision with enhances primary care, end of life and mental health cover to provide a hospital @ home model of care to prevent escalation of need and avoid admission/attendance	£200,000	Reduced ED attendances and avoidance admissions
Bromley CCG	Bromley Healthcare	Enhanced healthcare for ECH	Providing proactive support and clinical management to providers with the highest LAS call out rate	£50,000	Reduced LAS call outs, reduction in conveyance of patients, reduced readmission, reduced LOS for residents of ECH
Bromley CCG	Greenbrooks	Additional HCAs	Additional HCA cover in both UTC sites to improve productivity and increase capacity	£32,928	Maintain required performance during increased attendances
Bromley CCG	Greenbrooks	GP Enhanced Rates	Provide enhanced rates for hard to fill and last minute sessions	£16,000	Ensuring complete rota fill across evenings and weekends to ensure more patients can be seen in UTC reducing pressure on ED
Bromley CCG	Greenbrooks	Pt Champion 7 days per week	Extend exiting 5 day per week patient champion roll to 7 day service	£18,702	redirection and increase use of GP Hub appointments including advise and sign posting to avoid attendances
Bromley CCG	CCG	Enhanced community support for temporary health conditions	Providing additional resource to support more people to be discharged with temporary health conditions that do not meet the threshold for CHC funding	£100,000	Reduce stranded patients by being able to offer more temporary enhanced support for people in the community
Bromley CCG	BGPA	Additional hub appointments	Providing additional hub appointments during key pressure times	£50,000	More people to be seen in primary care mitigating increase in UTC attendance
Bromley CCG	BHC	ANP Home visiting service	Provide ANP support to undertake GP home visits, reducing demand on GP call out	£150,000	To support increase in demand for home visiting providing timely provision of visits to reduce demand on primary care and preventing escalation of need
Bromley CCG	CCG Comms	Winter Campaign	Cost still to be determined. Awaiting national plans to be disseminated	£10,000	Raising awareness of winter schemes locally and national issues
				£627,630	
LBB	LBB	Additional staff	Staff deployed across key locations as part of MDTs. Will enhance care management and assessment, reviewing, OT. Will both prevent admissions and support D2A. Staff will be deployed	£650,000	Reduction in admissions and DToC. Better coordination of care and support
LBB	Local provider market	Fast response personal care service provision the community	Discharge of patients within 2 hours upon receipt of their Discharge Notification (Passport). This service will also be offered to users with 'urgent needs' arising from a long-term medical conditions in the community, to avoid or prevent hospital admission. This will enhance the D2A domiciliary care offer.	£54,000	Reduction in admissions and DToC. More rapid and effective coordination of care and support
LBB	Local provider market	Intensive Personal Care Services	Intensive personal care service for patients with higher care and support needs, who would otherwise need to go into a care home or have recurrent admissions to hospital. These users may require up to 8 visits per day or 24 hour support for a maximum of two weeks.	£50,000	Reduction in admissions and DToC. More rapid and effective coordination of care and support
LBB	Local provider market	Extra care, residential and nursing placements	Commissioners will work with providers to incentivise prompt admissions to enable short-term support to avoid hospital and/or as part of D2A. This will enhance the block contract arrangements we have in place where full capacity (70 beds) is being phased in between now and December.	£263,000	Reduction in admissions and DToC. More rapid and effective coordination of care and support
LBB	Local provider market	Wrap around services	Handy person services, deep clean and associated services	£10,000	will enable patients homes to be ready for quick return from hospital, or to unable access for care to support hospital avoidance
				£1,027,000	

2018/19 Proposed PRUH Winter Schemes

Organsation	Scheme Title	Scheme Description	Cost commentary	Total cost (winter only)	Expected Impact	Priority this scheme addresses	Timescale for Implementation	Key Performance Indicator	KPI Baseline	KPI Target	Lead Person and contact details
Kings - PRUH	Ambulatory Streaming for medical referrals + Assessment unit	Provide 7 day extended hours ambulatory streaming for medical referrals in ED with accompanying assessment unit. To reduce admissions and support rapid turnaround of patients.	For sign off through Trust Business Case process	£ 281,061.48	Reduction in ED breaches and admissions	Addresses 7 day ambulatory care (7 day)	Full go live November pending business case	Medical admissions	Oct-18	Reduce by tbc per day	S. Frankton E. Garbelli
Kings - PRUH	Relocation and expansion of Discharge Lounge	Utilise existing phlebotomy clinic space for more suitably located and larger discharge lounge.	£50,000 (Pending final estates cost from Vinci)	£ 50,000.00	Improved pre 1pm discharge profile		Nov-18	Pre 1pm discharge	Oct-18	Increase by 10%	J. Edmonds G. Jackson
Kings - PRUH	Enhanced care in discharge lounge	Enable earlier vacation of ward beds by stepping up level of care available in discharge lounge for patients being dischaged that day.	For sign off through Trust Business Case process	£ 27,894.38	Improved pre 1pm discharge profile		Nov-18	Pre 1pm discharge	Oct-18	Increase by 10%	J. Edmonds
Kings - PRUH	Additional clinical admin for discharge lounge	Additional support to maximise discharges and maintain flow, including through pulling golden patients and ensure improved discharge quality (eg ensuring drugs always go with patient)		£ 19,671.25	Improved discharge profile and discharge quality.		Nov-18	Golden patient discharges before 1pm Discharges before 1pm	Oct-18	1) Increase by 20% 2) Increase by 10%	Tbc
Kings - PRUH	ED transfer team	Dedicated team to move admitted patients on from ED	For sign off through Trust Business Case process	£ 42,465.00	Wait for bed		Oct-18	ED wait for bed	Sep-18	Reduce wait for bed by 10%	S. Frankton tbc E. Garbelli tbc
Kings - PRUH	AMU transfer team	Dedicated team to move admitted patients on from AMU	For sign off through Trust Business Case process	£ 42,465.00	Wait for bed		Oct-18	AMU wait for bed	Sep-18	Reduce wait for bed by 10%	S. Frankton tbc E. Garbelli tbc
Kings - PRUH	PRUH ED B5 Ambulance Receiving Nurse	Enable early work-up of patients offloaded from ambulance and support their clinical safety.		£ 65,086.88	Safety of patients offloaded from ambulances in times of extreme pressure		Nov-18	Ambulance handover times	Oct-18	Maintain baseline	Tbc
Kings - PRUH	Full Capacity and internal communication protocols	Improved site responsiveness to pressures through improved cross site pressure communications and associated action cards. Includes full capacity protocol.	Minor costs to support communication	£ 5,000.00	Reduced length of stay		Oct-18	LoS	Sep-18	Reduce by 10%	A. Pirfo
Kings - PRUH	Standardised Board round Process, Tools and Training.	Full implementation of King's Way for Wards ahead by January 2019 (includes delivery of red to green)		£ 32,000.00	Improved pre 1pm discharge profile; reduced length of stay	Full implementation of SAFER and R2G Days; All patients receive senior review before midday by a clinician able to make management and discharge decisions (5 days a week)	In train, completes January 2019	Pre 1pm discharge LoS	Jun-18	1) Increase by 10% 2) reduce by 1 day	T. Clark H. Tompsett E. Atherton
Kings - PRUH	Ambulatory failty service at Orpington (Elizabeth Ward)	Provide 5 day, 8am to 5pm ambulatory frailty care at Orpington Hospital for direct referral, reducing ED attendances, reduce admissions and support early discharge.	For sign off through Trust Business Case process	£ 306,530.15	Reduction in ED attendance and admisisons [to be quantified]	Partially addresses 7 day ambulatory care (5 day)	Go-live end October 2018	ED attendances (seeking reporting on frailty score)	Sep-18	Reduce by 2 per day	N Dare Nick Yard, Service Manager
Kings - PRUH	Additional ED shifts to meet ECIST decision maker recommendations	Senior clinical-decision maker to improve triage, to improve use of non-ED based medical and surgical pathways, and to reduce delays for first clinician. 12:00 to 20:00 ST4-6 or consultant.	Full cost from October - March c.£180k: working to job plan and better utilise existing staff to bring to £120k.	£ 120,000.00	Reduce delays to first clinician in ED Increased use of ambulatory pathways		Aiming October 2018	Time to first clinician	Sep-18	Reduce by 10%	Tbc
Total Spend				**£992,174**							

2018/19 Proposed Winter Schemes

Priority order	Organisation	Scheme Title	Scheme Description	Cost commentary	Total cost (winter only)	Expected Impact	Priority this scheme addresses	Timescale for Implementation	Key Performance Indicator	KPI Baseline	KPI Target	Lead Person and contact details
1	Kings - PRUH	Increased resilience of Acute and Post Acute junior doctor rotas	Significant and early recruitment drive for junior doctors to fill available posts. [8 doctors over previous rotation with further posts to be filled]	Within funded posts	£ -	Reduced wait to first clinician and specialty opinion; improved cross site discharge profile.		Sep-18	ED wait to first clinician Wait for speciality opinion LoS	Aug-18	1 and 2 Reduce by 25% 3 Reduce from baseline by 1d.	S. Frankton J. Evans J. Edmonds
2	Kings - PRUH	Ambulatory Streaming for medical referrals + Assessment unit	Provide 7 day extended hours ambulatory streaming for medical referrals in ED with accompanying assessment unit. To reduce admissions and support rapid turnaround of patients.	For sign off through Trust Business Case process	£ 281,061.48	Reduction in ED breaches and admissions	Addresses 7 day ambulatory care (7 day)	Full go live November pending business case	Medical admissions	Oct-18	Reduce by tbc per day	S. Frankton E. Garbelli
3	Kings - PRUH	Relocation and expansion of Discharge Lounge	Utilise existing phlebotomy clinic space for more suitably located and larger discharge lounge.	£50,000 (Pending final estates cost from Vinci)	£ 50,000.00	Improved pre 1pm discharge profile		Nov-18	Pre 1pm discharge	Oct-18	Increase by 10%	J. Edmonds G. Jackson
4	Kings - PRUH	Extended Transfer of Care Bureau 7d 8am to 8pm	Full operation of ToCB functions to 8pm, 7 days a week.	To agree split with system		Improved discharge profile; reduced length of stay		Nov-18	Length of Stay	Oct-18	Decrease by 10%	tbc
5	Kings - PRUH	Trust-commissioned intermediate care beds	30 intermediate care beds	For sign off through Trust Business Case process. 4 months, based on external provider operating at care home (rent + care provision)	£1,200,000	Improved discharge and length of stay; Meeting national D2A policy.		December 2018 at latest	Length of Stay	Oct-18	Decrease by 10%	tbc
6	Kings - PRUH	Enhanced care in discharge lounge	Enable earlier vacation of ward beds by stepping up level of care available in discharge lounge for patients being dischaged that day.		£ 27,894.38	Improved pre 1pm discharge profile		Nov-18	Pre 1pm discharge	Oct-18	Increase by 10%	J. Edmonds
7	Kings - PRUH	Additional clinical admin for discharge lounge	Additional support to maximise discharges and maintain flow, including through pulling golden patients and ensure improved discharge quality (eg ensuring drugs always go with patient)		£ 19,671.25	Improved discharge profile and discharge quality.		Nov-18	Golden patient discharges before 1pm Discharges before 1pm	Oct-18	1) Increase by 20% 2) Increase by 10%	Tbc
8	Kings - PRUH	ED transfer team	Dedicated team to move admitted patients on from ED	For sign off through Trust Business Case process	£ 42,465.00	Wait for bed		Oct-18	ED wait for bed	Sep-18	Reduce wait for bed by 10%	S. Frankton tbc E. Garbelli tbc
9	Kings - PRUH	AMU transfer team	Dedicated team to move admitted patients on from AMU	For sign off through Trust Business Case process	£ 42,465.00	Wait for bed		Oct-18	AMU wait for bed	Sep-18	Reduce wait for bed by 10%	S. Frankton tbc E. Garbelli tbc
10	Kings - PRUH	Mortuary expansion	Expansion of mortuary to meet 17/18 demand plus growth. In 17/18 PRUH utilised Croydon Heath Services mortuary capacity, however this will not be available in 18/19 due to CHS having won the Croydon coroner's contract.	For sign off through Trust Business Case process	£612k	ED cubical and ward bed availability		tbc	ED wait for bed	2017/18	Maintain baseline	S. Mitchell-Hall
11	Kings - PRUH	PRUH ED B5 Cohort Nurse	Enable early work-up of patients offloaded from ambulance and support their clinical safety.		£ 65,086.88	Safety of patients offloaded from ambulances in times of extreme pressure		Nov-18	Ambulance handover times	Oct-18	Maintain baseline	Tbc
12	Kings - PRUH	Full Capacity and internal communication protocols.	Improved site responsiveness to pressures through improved cross site pressure communications and associated action cards. Includes full capacity protocol.	Minor costs to support communication	£ 5,000.00	Reduced length of stay		Oct-18	LoS	Sep-18	Reduce by 10%	A. Pirfo
13	Kings - PRUH	Use of MADE at key points through winter	Days to be agreed with system partners for MADE at key points during winter, in addition to existing twice weekly stranded patient review meetings	Opportunity cost only	£ -	Reduced length of stay; reduced stranded patient number	Use of MADE throughout winter	December 2018 at latest	Stranded patients Super stranded patients	Sep-18	Reduce by 20% following MADE	A. Pirfo

14	Kings - PRUH	Standardised Board round Process, Tools and Training.	Full implementation of King's Way for Wards ahead by January 2019 (includes delivery of red to green)	£32,000	£ 32,000.00	Improved pre 1pm discharge profile; reduced length of stay	Full implementation of SAFER and R2G Days; All patients receive senior review before midday by a clinician able to make management and discharge decisions (5 days a week)	In train, completes January 2019	Pre 1pm discharge LoS	Jun-18	1) Increase by 10% 2) reduce by 1 day	T. Clark H. Tompsett E. Atherton
15	Kings - PRUH	Ambulatory failty service at Orpington (Elizabeth Ward)	Provide 5 day, 8am to 5pm ambulatory frailty care at Orpington Hospital for direct referral, reducing ED attendances, reduce admissions and support early discharge.	For sign off through Trust Business Case process	£ 306,530.15	Reduction in ED attendance and admisisons [to be quantified]	Partially addresses 7 day ambulatory care (5 day)	Go-live end October 2018	ED attendances (seeking reporting on frailty score)	Sep-18	Reduce by 2 per day	N Dare Nick Yard, Service Manager
16	Kings - PRUH	Additional AMU Consultant	Increase AMU resilience and flow through winter.		£ 62,500.00	Reduced AMU LoS		Oct-18	AMU LoS	Sep-18	Reduce AMU LoS by 10%	S. Frankton tbc E. Garbelli tbc
17	Kings - PRUH	Criteria Led Discharge for Elective and Emergency surgical patients	Criteria led discharge for all surgical patients to facilitiate reduction in length of stay.	Opportunity cost only	£ -	Reduced length of stay		tbc - October 2018	Surgical LoS	Sep-18	Reduce by 10%	N. S Kumar J. Allen C. Noone F. Smedley
18	Kings - PRUH	Ambulatory Streaming for Surgical referrals + Surgical Assessment unit	Provide 7 day extended hours ambulatory streaming for surgical referrals in ED with accompanying assessment unit. To reduce admissions and support rapid turnaround of patients.	For sign off through Trust Business Case process	£ 880,747.14	Reduction in ED breaches and admissions	Addresses 7 day ambulatory care (7 day)	Pilot September 2018; Full go live November pending business case	Surgical admissions	Oct-18	Reduce by tbc per day	T. Signal N. S Kumar
19	Kings - PRUH	Additional clinical admin for ED	Additional support to maximise discharges and maintain flow		£ 19,671.25	Improved discharge profile from ED		Nov-18	ED breaches	Oct-18	Maintain baseline	Tbc
20	Kings - PRUH	Additional clinical admin for Acute Medicine	Additional support to maximise discharges and maintain flow		£ 19,671.25	Improved discharge profile		Nov-18	Medical discharges before 1pm	Oct-18	Increase by 10%	Tbc
21	Kings - PRUH	Additional clinical admin / discharge co-ordinator for Post Acute Medicine	Additional support to maximise discharges and maintain flow		£ 19,672.25	Improved discharge profile		Nov-18	Medical discharges before 1pm	Oct-18	Increase by 10%	Tbc
22	Kings - PRUH	Additional cleaning to support IPC	Double up where single cleaner available out of hours to reduce waits for cleans	tbc £50000 indicative (Vinci / ISS)	£ 50,000.00	Beds lost to IPC		Nov-18	Beds lost to IPC	Same month previous year	Reduce by 10%	tbc
23	Kings - PRUH	In ED 'flu testing	Learning from St George's 2017/18 in ED Testing to more accurately cohort patients and inform clinical decision making.	tbc - await detail from St George's		Beds lost to IPC		Nov-18	Beds lost to IPC	Same month previous year	Reduce by 10%	tbc
	Total Spend			**£0**	**£3,124,436**							

APPENDIX 7

Daily Management of Repatriations and Referrals to and from the Princess Royal University Hospital

The coordination of repatriations and referrals to and from the PRUH is the responsibility of the Orpington Clinical Site Practitioner. Required escalation will be directed through the PRUH site's operational lead.

Mission Statement

- All referrals for treatment and repatriation to the PRUH will be accepted and relocated within 48hrs.
- All referrals for treatment and repatriation from the PRUH will be escalated to the operational lead at each relevant capacity meeting on exceeding a 48hr wait.
- An electronic record of activity will be maintained daily by the Orpington CSP and stored in the I Drive.
- A minimum of 1 repatriation per day will be absorbed into PRUH's in-patient bed base when the list is occupied.
- Repatriations accepted for admission should arrive prior to 17:00 hrs.
- Any exceptions to the above will be directed by the PRUH site's operational lead. .

Process

- Daily repatriation requirements to be assessed by the Orpington CSP, using daily repatriation tracker. Actions to be delegated to the appropriate CSP.
- All repatriation/transfer patients to be communicated daily with respective Site/Bed managers
- Repatriation requirements and plan to be communicated at 08:15 bed meeting.
- Finalisation of plan to be confirmed at 12:15 bed meeting.
- Any repatriation admitted on the day should be entered on to the appropriate speciality's emergency admission log.
- Speciality on call registrar to be informed of patient accepted on the day.
- All communication to be documented on a daily basis in the additional comments row.
- Daily repatriation activity to be discussed at the Clinical Site Practitioners evening handover (PRUH & Orpington) using updated repatriation tracker (Orpington only). The next day's tracker to be saved at evening handover with completed repatriations deleted.

- New referrals for external transfer/repatriation will be referred to the Orpington CSP for data collection, entry to the repatriation tracker and action.
- New referrals from tertiary hospitals will be referred to the Orpington CSP for data collection, entry to the repatriation tracker and action.
- Denmark Hill (DH) to PRUH referrals will be collected by DH repatriation team; repatriation tracker will to be updated at DH.

Data Collection and Daily Record

- All repatriation data will be stored on a daily database on the I Drive. Located by clicking; *Computer → I Drive → Clinical Site Management → Repatriation → Repatriation Tracker.*
- The repatriation tracker has 3 tabs; Tab 1 PRUH Repats out – For PRUH patients waiting for speciality beds elsewhere or repatriation. Tab 2 DH to PRUH repats – For patients waiting at Denmark Hill for PRUH beds. Tab 3 Tertiary to PRUH repats – For patients in Hospitals external to King's College NHS Foundation Trust.
- Daily Repatriation tracker to be saved with the date and initials of the Orpington CSP in the following format: KCH-PRUH RepatsDDMMYYYY(GJ)

Bromley OOB Referral Process Map

RESTARTS

- ✓ Complete restart checklist
- ✓ Email to: Domcare.duty@bromley.gov.uk
- ✓ Await confirmation from brokerage

Tel: 01689 864583

Note: NOA/NOD NOT REQUIRED

CCG

Fully funded Fast Track

Complete CHC Checklist and submit to CCG for ratification and next steps

Complete Fast Track tool and submit to Bromley CCG for ratification BROCCG.continuingCarereferrals@nhs.net

Reablement/ NEW/Increase POC/ ECH Non-weight baring (DoH)

- ✓ NOA / NOD required
- ✓ Send functional Therapy report
- ✓ If double handed – CHC Checklist including ratification required

Note: ***Patient should not be considered for Reablement if BBR / HBR apply (Please see REHAB)***

Once POC agreed, the Brokerage Team will broker care and agree start date with Care Manager
Domcare.duty@bromley.gov.uk
Tel: 01689 864583

REHAB

For Home base Rehab/ Bed Base Rehab

- ✓ Complete and send Bromley Healthcare referral to Bromley Healthcare:

BROMH.bromleyrehab@nhs.net

HBR – 02083158722
BBR – 02083158721

BHC will contact referrer to confirm acceptance and arrange transfer

PLACEMENT (Social Care)

- ✓ Complete CHC Checklist

If Checklist triggers follow CHC Process

Negative Check List

- ✓ NOA & NOD required
- ✓ Send a copy of the
  - CHC checklist
  - Functional Therapy report
  - Further supporting evidence e.g functioning charts, to Bromley Social Services

Once placement agreed Care Placement Team (CPT) will source an appropriate placement, communicating with the family and the ward
020 8461 7926/7425

NOA / NOD sent to: hospital.discharge@bromley.gcsx.gov.uk

Non-admitted patients requiring social care input should be encouraged to return home and request an assessment from the community directly via the Early Intervention Service on 0208 461 7777
adult.early.intervention@bromley.gov.uk
https://bromley.mylifeportal.co.uk

USEFUL CONTACT NUMBERS

Age UK
0208 315 1850

CareLink
0208 313 4979

Bromley Well

Carol Rickell
Hospital Link Worker

075 0624 7822

Bromley Homeless Unit / Housing

0208 313 4098

Early Intervention Team (social care)
0208 461 7777

Emergency Duty Team – Out of Hours (5pm – 8am)

0300 303 8671

Extra Care Housing Units

Crown Meadow Court
0208 462 1006

Regency Court
0208 460 3142

Sunderland Court
0208 659 3161

Durham House
0208 313 4098

SOCIAL CARE ESCALATION

Beverley Martin (Stage 1)
Tel – 01689 864575
beverley.martin@bromley.gcsx.gov.uk
Lisa Barnard (Stage 2)
Tel: 01689 863081
lisa.barnard@bromley.gov.uk
Sharon Edwards (Stage 3)
Tel: 01689 864598
Sharon.edwards2@bromley.gcsx.gov.uk

Reablement
Reablement, provided by London Borough of Bromley should be considered for all Bromley residents where they appear to have the potential to relearn daily living skills and regain confidence to live independently. It can also be considered either following assessment or review to support the fine tuning of a support plan. The core areas in which the client has reablement potential and should be reflected in the Care Act outcomes which are: Washing, Dressing, Toileting, Preparing meals, Community activities services and Medication (if part of package of care). Re-ablement service can be provided for up to 6 weeks.

Home and Bed Based Rehab
Provided by Bromely Health Care delivering up to 6 weeks rehab at home (HBR) or in a bedded nurse led unit (Lauriston House)

- Patient over the age of 18
- Patient has a Bromley GP
- Patient has been declared medically fit for discharge home or to Lauriston House (BBR) by the medical team
- Will have consented to accept service and participate in rehab
- Should benefit from assessment/interventions from more than 1 rehabilitation discipline
- Patient is expected to return home or have discharge destination (excluding nursing homes)
- Have the potential to improve significantly within 6 weeks- on their current level of function (mobility), approaching their level of function prior to admission
- Demonstrate the ability to retain information/carry over from session to session in order to benefit from rehabilitation and achieve goals
- **BEDS ONLY** Demonstrate physical endurance to participate in a rehabilitation program (2 hours sitting balance and ability to participate in therapy, including ADL's, for at least 45 minutes twice a day on admission
- **BEDS ONLY** Unsafe to managed at home and requires a bedded pathway- must be predictably medically stable enough not to need acute hospital care.

Care Placement Team (CPT)
Dedicated placement brokerage team for all LBB placements. Once placement funding has been agreed panel a dedicated CPT Officer will manage the case including family liaison and communicating with the ward.
The CPT Officer will discuss preference with the family and try, wherever possible to meet the families requirements straight from hospital, however if this is not possible immediately, then a 'suitable offer' will be made as an interim so the person does not need to remain in an acute bed. The family then have more time to source the placement of Choice with CPT providing advice & support.
Where a suitable offer is made the acute trust will be required to take forward the discharge to that destination in a timely manner.

Brokerage
Once the POC or increased POC has been agreed the brokerage service will source a provider and communicate with the allocated care manager to agree a discharge date and time. The care manager will then update the family and the ward.

Extra Care Housing
Step down units are in place to facilitate a timely discharge and provide up to 6 weeks for the individual to be assessed for suitability and put in place permanent ECH tenancy. This is accessed via the Care Manager through a NOA and agreed outside of panel

Panel arrangements in Bromley
There is a weekly social care panel on a Thursday however all cases can be read outside of panel to support timely discharge.

A decision on CHC eligibility can also be made by the duty nurse and does not always require waiting for a panel. A decision can be made within 24 hours for checklist and DST ratification with fast track paperwork being agreed on receipt wherever possible. All pending correct completion of documentation.

Report No.
CS18184

London Borough of Bromley

Decision Maker:	**HEALTH AND WELLBEING BOARD**
Date:	**27th September 2018**
Decision Type:	Non-Urgent Non-Executive Non-Key
Title:	**BETTER CARE FUND AND IMPROVED BETTER CARE FUND 2018/19 Q1 PERFORMANCE REPORT**
Contact Officer:	Jackie Goad, Executive Assistant, Chief Executive's Department Tel: 020 8461 7685 E-mail: Jackie.Goad@bromley.gov.uk
Chief Officer:	Ade Adetosoye, Deputy Chief Executive and Executive Director of Education, Health and Care Services, London Borough of Bromley Angela Bhan, Manager Director, NHS Bromley Clinical Commissioning Group
Ward:	Borough-wide

1. Summary

1.1 This report provides an overview of the performance of both the Better Care Fund (BCF) and the Improved Better Care Fund (iBCF) 2018/19 on both expenditure and activity for the first quarter period between April and up to the end of June 2018.

2. Reason for Report going to Health and Wellbeing Board

2.1 This is the first combined performance report for both the Better Care Fund and the Improved Better Care Fund.

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

3.1 That the Health & Wellbeing Board notes the performance and progress of both the BCF and iBCF schemes as well as the latest financial position for the first quarter.

Health & Wellbeing Strategy

1. Related priority: Not Applicable

Financial

1. Cost of proposal: BCF: £22,670k for 2018/19; iBCF: up to £5,661k in 2018/19
2. Ongoing costs: iBCF: £1,390k in 2019/20
3. Total savings: Not Applicable
4. Budget host organisation: LBB
5. Source of funding: Section 31 Grant, Ministry of Housing, Communities & Local Government (previously DCLG)
6. Beneficiary/beneficiaries of any savings: London Borough of Bromley and Bromley CCG

Supporting Public Health Outcome Indicator(s)

Not Applicable

---

4. COMMENTARY

4.1 The Better Care Fund (BCF) grant is ring fenced for the purpose of pooling budgets and integrating services between Bromley Clinical Commissioning Group (BCCG) and the local authority.

4.2 The Improved Better Care Fund (iBCF) was a new funding element added to the Better Care Fund from 2017-18 which is paid to local government as a direct LA grant for spending on adult social care. The 2017 Spring Budget announced additional funding for social care from 2017-18 to 2019-20.

4.3 In order to ensure that local areas are meeting the standard conditions of the Fund it is a requirement to report back to NHS England on a quarterly basis progress against the agreed plan including expenditure.

4.4 The purpose of this report is to provide the Health & Wellbeing Board with an overview of the first quarter performance for the Better Care Fund and the Improved Better Care Fund for 18/19.

4.5 The London Borough of Bromley was awarded an iBCF grant of £4.2m in 2017/18, £3.4m in 2018/19 and a further £1.7m for 2019/20.

4.6 **Better Care Fund - Performance Metrics**

4.7 Bromley is responding to the following national metrics with the BCF

a. Reduction in non-elective admissions

b. Delayed transfers of care (DTOCS) (delayed days)

c. Rate of permanent admissions to residential care per 100,000 population

d. Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services.

4.8 a. Non-elective admissions (emergency admissions)

	NE Admissions	Actual Performance#	Quarterly Plan	Variance
Apr-18	1975			
May-18	2230			
Jun-18	2111	**6316**	**6589**	**-273**

#Actual performance is derived from SUS activity.

4.9 The Quarter 1 figures show that Bromley has seen a positive reduction in non-elective admissions against the BCF plan. The Integrated Care Networks Pro-active care pathway is now established to manage the care planning for patients identified by practices as a risk of escalating need. This multi-disciplinary model, delivered by the an alliance of the Bromley acute, community and primary care providers, supported by Social Care, has been developed as model of Integrated Care across Bromley.

4.10 The current model is now currently being reviewed and changes being developed to further increase the effectiveness of the service. In addition to this, the development of the Bromley Hospital at Home service will also have a positive impact on managing emergency admissions to the Hospital.

4.11 b. Delayed Transfers of Care (DToCS)

4.12 In compliance with the national 2017-19 BCF plan condition, the DTOC joint action plan sets out Bromley's agreement to reduce delayed transfers of care. For 18/19 Bromley's target has increased from 10.31 bed days per day to 12.5.

4.13 For the first quarter positive results were attained with each month achieving above the monthly set target.

		18-19 plans			
		Q1 (Apr 18 - Jun 18)	Q2 (Jul 18 - Sep 18)	Q3 (Oct 18 - Dec 18)	Q4 (Jan 19 - Mar 19)
Delayed Transfers of Care (delayed days)	**Number**	**1137.5**	**1150.0**	**1150.0**	**1125.0**

		18-19 actuals#			
		Q1 (Apr 18 - Jun 18)	Q2 (Jul 18 - Sep 18)	Q3 (Oct 18 - Dec 18)	Q4 (Jan 19 – Mar 19)
Delayed Transfers of Care (delayed days)	**Number**	756			

Actual performance derived from NHS England Delayed Transfers of Care Data 2018/19 https://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/

4.14 Please refer to the separate update report on Delayed Transfer of Care performance (CS 18185) which provides a more detailed update on published and local performance to date.

4.15 c. Admissions to residential care

		Planned 18/19	Qtr 1 Actual	Qtr 2 Actual	Qtr 3 Actual	Qtr 4 Actual
Long term support of older people (aged 65 and over) met by admission to residential and nursing homes per 100,000 population (57,626 in Bromley)	**Number**	425.0 (245 admsns)	81.6 (47 admsns)			

4.16 During the first quarter there were 81.6 or 47 admissions into residential and nursing care. In comparison there were 95.9 or 55 admissions made during the same quarter period for 17/18. Admission numbers are fluid due to seasonal variations but Bromley continues to robustly scrutinise recommendations for placements and ensure that community alternatives have been fully explored.

4.17 d. Reablement

		Planned 18/19	Qtr 1 Actual	Qtr 2 Actual	Qtr 3 Actual	Qtr 4 Actual
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	**Annual %**	90.1%	100%			
	Number	446/495	27/27			

4.18 As at the end of June the percentage of people still at home 91 days after discharge was 100%. In comparison the percentage of people still at home during the same quarter period for 17/18 was 92%. The use of Bridging is proving successful in moving secondary users through pathways of care.

4.19 **Update on BCF Schemes**

i) Self-Management & Early Intervention

4.20 Performance information on the Bromley Well service up to the end of March 2018 was reported to members in the previous BCF performance report presented in July. The table below provides the breakdown of referrals into the individual services of Bromley Well received through the Single Point of Access (SPA) between April to the end of June.

Services	Q1 April – June'18
Long Term Health Conditions	709
Elderly Frail	991
Employ & Education	149
Learning Disabilities	90
Physical Disabilities	125
Carers (Adult & MH)	326
Young Carers	49
Mutual Carers	46
Mental Health	290

4.21 A Bromley Well workshop was held on 16th May with LBB, Bromley Clinical Commissioning Group (BCCG) and Bromley Third Sector Enterprise (BTSE) colleagues to review service provision so far and to agree an action plan for future development of the service.

ii) Discharge to Assess (D2A)

4.22 In October 2017 Executive approved the use of BCF underspend to pilot Discharge to Assess (D2A) in Bromley. D2A seeks to reduce delayed transfers of care (DToC) and the impact that prolonged hospital stay has on frail and elderly individuals by offering access to immediate wrap around care and support in the community, reducing length of hospital stay in order for the assessment of long term care and support needs to be undertaken in a more familiar setting.

4.23 The pilot was mobilised during the busiest winter in the history of the PRUH and has so far supported 226 people that met the Care Act threshold for assessment and support. Reductions in the length of stays have also reduced from 32 days in the initial months of the pilot to 21 days with some people transitioning off as close to 3 days post hospital discharge.

4.24 Early findings from the pilot have been extremely positive showing encouraging results in reduced levels of care, improved outcomes and more efficient service delivery.

4.25 It was recommended to Executive in July that the pilot be extended for a further 12 months so that the full potential benefits to the system can be evaluated. Executive approved the recommendation and the drawdown of further underspend to support the extension of the pilot.

4.26 **Update on progress for Integration of Health and Social Care**

4.27 During the final quarter of 17/18 both LB Bromley and Bromley Clinical Commissioning Group (BCCG) agreed proposals to further develop and strengthen joint working arrangements particularly operational arrangements in order to make quicker progress on our local journey towards integration.

4.28 An implementation plan has since been drawn up to cover the first phase of the work from June 2018 - March 2019. The plan anticipates progress in the following main areas:

- Defining and agreeing the scale and scope of the future integrated commissioning arrangements
- Developing and strengthening formal governance arrangements including the creation and agreement of a formal Partnership Agreement between the partner agencies and the further development of the leadership role of the Integrated Commissioning Board
- Recruitment and appointment of a substantive Joint Director of Integrated Commissioning
- The creation of an integrated commissioning team, joining-up existing teams into a combined unit under single leadership and developing a proposal/business case for co-location of the new integrated team.

4.29 **Update on iBCF Schemes**

4.30 The iBCF schemes reflect the three grant conditions that the fund be used only for the purposes of:

- Meeting Adult Social Care needs

- Reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready

- Ensuring that the local social care providers market is supported.

4.31 **Assessed and Supported Year in Employment (AYSE) Lead and Placements Coordinator**

4.32 Further to the previous IBCF performance update report to members (Report CS18139) the ASYE Lead Post was upgraded to full time hours and an internal candidate has now been successfully appointed and will be in post to welcome the newly qualified social workers in to post

4.33 The Placements Co-ordinator is also in post and is working closely with South East London Colleges (Bromley campus) to develop robust learning opportunities and placement opportunities for students following completion of their Level 3 Health & Social Care Diploma and also with local care homes to help retain existing carers by developing a clear career pathway (including bespoke training and part/full funded qualifications).

4.34 A scoping exercise has been carried out with the college looking at the key areas where care homes believe students need more experience. The college is confident that a more focused approach on placement content and a financial incentive for the care homes hosting the placements will improve the number of carers that come into the profession and more importantly, stay in the profession.

4.35 A meeting with final year students, facilitated by the college, is due to take place at the end of August to gauge how many students would like this opportunity in line with college enrolment dates.

4.36 The suggested approach to help retain existing carers is to create individualised pathways with each care home in line with their organisation structure and required specialism (e.g. progression to senior carer/care home manager) and for LBB to allocate funding for the development of identified staff to embark on this pathway. A number of contracted care homes have expressed interest in this approach and a meeting has been arranged in September to discuss pathways already in place and to help inform next steps.

4.37 **Process and Systems Coordinator**

4.38 The Process and Systems Coordinator has also been appointed and is working closely with the project support officer on the Integrated Care Network and Continuing Health Care work as well as looking at the processes used in the front end of the service. There is still significant work to be done before any outcomes can be reported.

4.39 **Continuing Health Care (CHC) Lead Social Worker and CHC Care Manager**

4.40 Due the continuing difficulties in appointing a lead social worker it has been agreed to advertise internally for a senior care manager level assessor to see if a care manager would be interested to take on case work and other duties.

4.41 The part time care manager has been in post since November 2017 and is making a difference in terms of improvements in practice and training for staff. During the Q1 period a total of 17 care managers were trained making a total of 66 since January. The training takes into account the new guidelines on continuing care which are being issued to all staff.

4.42 Progress is also being made to improve practice procedures and protocols, including further work to streamline the finance system for the collating of appropriate data from both health and social care joint funding and also for those who then become fully funded by Bromley Clinical Commissioning Group (BCCG). Both these issues are noted as priority work.

4.43 **Occupational Therapy Review/Trusted Assessor Resource**

4.44 Staff have now been formally consulted on the Occupational Therapy service restructure following the service review which identified a proposed fit for purpose service structure to enable the service to meet current levels of demand and to avoid future unmanageable backlogs.

4.45 The Head of Service has continued with the secondment arrangements so that actions in stage 1 and 2 of the review can continue to be progressed rather than delay them whilst the recruitment process goes ahead. The recruitment process is underway and it is hoped that the new structure will help Bromley to attract Occupational Therapy staff.

4.46 Trusted Assessor is part of stage 2 of the review and this will be reported on at the next update along with progress of recruitment.

4.47 **Transitions Programme Lead**

4.48 The DfE 'Preparing for Employment' grant which seeks to support young people with SEND to progress into employment has now been finalised and market facilitation has been completed. The tender closes 7th September with the intention to award being made shortly thereafter.

4.49 Contribution has also been made to the adult social care review with a focus on transition including recommendations for changes required to the way we plan and support transition from children's to adult social care.

4.50 **Investment in 'Just Checking' software**

4.51 The 'Just Checking' technology has now been installed in 3 individual supported living schemes with service users with learning disabilities. The software pilot will run for 3 months and will provide a summary of activity monitoring designed to help understand the individuals' needs and whether their care packages are appropriate or could be adjusted.

4.52 Initial results are very encouraging showing within the first 4 weeks of using the technology that both service users and staff have seen that for certain periods of the night that night staff are not required.

4.53 The results of the pilot will be fully evaluated by the end of September but initial thoughts suggest that this technology could be introduced in appropriate LD supported living schemes and homes in order to replace costly waking night staff.

4.54 **Public Health - Supporting JSNA priorities**

4.55 The substance misuse pilot was due to commence in June however due to difficulties in recruiting a social worker with the required skills, the pilot has been delayed. An internal secondment has however now been agreed and it is envisaged that the post holder will be in place by the end of September.

4.56 **Housing Initiatives and research into older peoples housing needs**

4.57 The Older Persons survey is now underway with the target date for completion in October. A conference with housing partners at this stage will look at key findings.

4.58 **Care Homes Investment Options Appraisal**

4.59 The initial business case to explore the benefits and risks to LBB purchasing or building a local care home to assist with alleviating the increasing pressure of securing local nursing home placements has now been completed. The initial business case will be used to determine if the case is sufficiently strong to proceed to full business case stage, where an approved budget and commissioning of specialist providers would be required. The date to present the business case for formal decision to Executive is yet to be confirmed.

4.60 **Support for Integrated Care Networks (ICNs)**

4.61 The three care managers are now located in each of the ICNs and information relating to the number of carers assessments carried out as a result of people identified by ICNs is now being collated. This will also be evidenced through the analysis of the ICN caseload for each care manager responsible for performance in this area.

4.62 Analysis of the number of adult social care users identified through the ICNs has now commenced and will be produced monthly to show what difference is being made in regard to reductions overall.

4.63 The table below shows a comparison of the activity during the same Q1 period for 2017/18 and since LBB staff commenced in the ICN hubs in April 2018.

	Apr-Jun'18 Referrals direct to CM in ICNs	Apr-Jun'17 Referrals direct to Early Intervention
No of contacts with ICNs	**197**	189
% known to Adult Social Care (tracked through the NHS number)	**66%**	58%*
No. receiving a care package who had not previously	**9**	10
Unchanged care package	**33**	28
Increase in care package	**19**	28
Decrease in care package	**14**	10
Total contacts with ICNs between Jan 2017 – Jan 2018	**1930**	550*
Average age of users	**79**	82
% Female	**52%**	61%
% Male	**48%**	39%

Data Source: Derived from ICN Proactive Pathway Spreadsheet 2018-06-08LBB Note: Data compares Q1 2018/19 with Q1 2017/18 except * which was taken from ICN Update Executive Report 9th October 2017

4.64 Although still in its infancy, early analysis of the performance information indicates some potential positive outcomes in terms of reduction and stability of care packages.

4.65 Key next steps include reviewing assessment information inputted into Carefirst, reviewing workloads and the impact of the LLB staff within the ICNs.

4.66 **Discharge to Assess (D2A) in Extra Care Housing**

4.67 The 3 additional units at Norton Court have now been converted to stepdown flats, with appropriate furniture and assured shorthold tenancy agreements now in place.

4.68 A case has put forward for an additional FTE locum within the ECH team to assist with the suitable and efficient management of the additional flats as well as to address some of the issues currently blocking some of the other step down facilities. The post will work closely with the hospital D2A team.

4.69 A data monitoring system has now been created to track the utilisation of all stepdown flats at Norton Court and will capture information from June 2018 onwards.

4.70 **Safeguarding – South London and Maudsley (SLAM)/Oxleas/Priory**

4.71 A review of the response to safeguarding identified gaps in the provision to manage safeguarding investigations effectively within community and hospital settings in relation to mental health. IBCF money was therefore allocated to provide additional resources for ongoing work with Oxleas NHS Trust, The Priory and SLAM to ensure the authority is compliant with its safeguarding duties and delegations under the Care Act 2014.

4.72 Additional staff to manage safeguarding casework have now been recruited and the project manager is also in post.

i) SLAM

4.73 An established project action plan continues to guide the work of the group which has included the implementation of amended safeguarding referral pathways to ensure that Bromley now has oversight of all safeguarding across the site. Work in respect of a communication and training audit to determine understanding and staff awareness of how to refer safeguarding concerns is ongoing which has resulted in a gradual increase of referrals as the awareness and training has improved in relation to making appropriate referrals for concerns.

4.74 Work is also being undertaken to provide support and advice with the aim of improving the quality of safeguarding referral information.

ii) Oxleas NHS Foundation Trust

4.75 LBB commissioners and the project manager are currently developing a specific work plan for Oxleas which will include a number of areas to be reviewed including safeguarding responsibilities under section 31 and section 75, current safeguarding training levels and safeguarding practices across the Trust.

iii) Priory

4.76 Work with the Priory has yet to commence.

4.77 Overall next steps includes the creation of a data dashboard for mental health safeguarding to provide regular and accurate data giving an oversight of safeguarding activity and processes within our mental health services in Bromley and also developing an exit strategy for safeguarding referral in respect of Bethlem Royal Hospital site to Oxleas.

4.78 **Direct Payments Lead**

4.79 An end to end review of the direct payments process has now been undertaken and a short list of options and a document setting out the analysis and recommendations for change is due to be considered in September for decision on how to proceed.

4.80 The results of the DP user survey are currently being analysed and a summary of the results is expected by the end of August. The user survey included a number of questions relating to the support for people with a direct payment and also whether those with direct payments would like

to be involved in co-designing future support options. Approximately twenty people have indicated that they would like to be involved when the meetings take place in September.

4.81 The co-design process will inform future commissioning intentions and which will be brought back to the project board for further discussion.

4.82 **Market Development and Support**

4.83 This work continues to be coordinated by the joint LBB/BCCG Care Homes project and iBCF funds are being used to fund a temporary project lead and going forward will be used to support the work of the care homes project.

4.84 In terms of key milestones, the Care Homes Board coordinator has provided outline analysis of spend across both BCCG and LBB and a report with options for stronger, integrated market management will be reviewed by the board in October.

4.85 The survey of providers continues to be conducted as part of the training and staff development review and which is due to be completed by October. It is also envisaged by the end of October that an outline quality framework for nursing homes will be agreed.

5. IMPACT ON VULNERABLE PEOPLE AND CHILDREN

5.1 All services are designed to avoid people who are vulnerable reaching the point of crisis where they would be seeking support of statutory services and/or requiring unplanned admission.

5.2 The Improved Better Care Fund is for investment into adult services and will have a positive impact on vulnerable people through investment into safeguarding and adult social care.

6. FINANCIAL IMPLICATIONS

6.1 Due to the late implementation of the iBCF projects during 2017/18 the Executive, at its meeting on 21st May, approved the recommendation to carry forward underspend totalling £3.172m into 2018/19.

6.2 BCF underspend of £519k at the end of 17/18 has also been carried forward into the new 2018/19 financial year to be used against BCF projects.

6.3 The budget and expenditure for both the Better Care Fund and the Improved Better Care Fund are detailed in the tables below.

BCF - QUARTER ONE

Description	2018/19 budget £'000	Forecast Apr to Jun £'000	Forecast Jul to Sep £'000	Forecast Oct to Dec £'000	Forecast Jan to March £'000	Forecast Outturn £'000	Difference bud/act £'000
Reablement capacity	853	213	213	213	213	853	0
Winter Pressures Discharge (CCG)	646	162	162	162	162	646	0
Winter Pressures Discharge (LBB)	1,027	257	257	257	257	1,027	0
Integrated care record	433	108	108	108	108	433	0
Intermediate care cost pressures	625	156	156	156	156	625	0
Community Equipment cost pressures	422	106	106	106	106	422	0
Dementia universal support service	520	130	130	130	130	520	0
Dementia diagnosis	620	155	155	155	155	620	0
Extra Care Housing cost pressures	418	105	105	105	105	418	0
Health support into care homes/ECH	314	78	78	78	78	314	0
PSIS Contract	1,681	420	420	420	420	1,681	0
Risk against acute performance	1,347	337	337	337	337	1,347	0
Transfer of Care Bureau	611	153	153	153	153	611	0
Protecting Social Care	8,977	2,244	2,244	2,244	2,244	8,977	0
Disabled Facilities Grants - CAPITAL	1,995	499	499	499	499	1,995	0
Carers Funding	527	132	132	132	132	527	0
Reablement Funds	952	238	238	238	238	952	0
Reablement Funds	315	79	79	79	79	315	0
Contract reduction	150	38	38	38	38	150	0
Programmes Team	36	9	9	9	9	36	0
Unallocated funding	199	0	0	0	0	0	-199
Total Recurrent Budget	**22,667**	**5,617**	**5,617**	**5,617**	**5,617**	**22,468**	**-199**

IBCF 2018/19

	2018/19 £'000 BUDGET	2018/19 £'000 ALLOCATED	2018/19 £'000 UNALLOCATED
Transformation of Social Care (Adults, Mental Health & LD) / workforce development	430	149	281
CHC Lead Social Worker/Care Manager	135	56	79
Safeguarding Project Lead (3 days per week)	20	20	0
General project work	50	35	15
IBCF/BCF programme Mgr. ongoing	43	0	43
Finance Lead to support IBCF and BCF	170	85	85
Assistive Technology	50	12	38
Transitions Programme Lead	100	50	50
OT and Trusted Assessors Resources	8	8	0
Public Health, Supporting JSNA priorities	60	45	15
Housing initiatives and research into older peoples housing needs	160	0	160
Care Homes Investment Options Appraisal	1,566	0	1,566
Support for Integrated Care Networks (ICNs)	854	789	65
Discharge to assess in Extra Care Housing (ECH)	580	150	430
Safeguarding – SLAM	228	156	72
Direct Payments Lead	77	27	50
Market development and support	130	0	130
LD/ASC Growth as part of the Medium Term Financial Strategy	3,013	3,013	0
Total committed spend	**7,674**	**4,595**	**3,079**
Grant allocation	**-8,547**		
Unallocated IBCF	**-873**		

6.4 Any underspends or unallocated amounts on each project can be carried forward into the next financial year if necessary. Quarterly reports are required by Government to show the progress of the BCF/IBCF schemes.

7. LEGAL IMPLICATIONS

7.1 The Care Act 2014 amended the NHS Act 2006 to provide the legislative basis for the Better Care Fund. It provides the mandate to NHS England to include specific requirements relating to the establishment and use of an integration fund. NHS England and the Government allocate the Better Care Fund to local areas based on a framework agreed with Ministers.

7.2 The amended NHS Act 2006 gives NHS England the powers to attach conditions to the payment of the Better Care Fund. For 2017-19 NHS England set the following conditions to access the CCG element of the funding:

- The requirement that the Better Care Fund is transferred into one or more pooled funds established under Section 75 of the NHS Act 2006.

- The requirement that Health & Wellbeing Boards jointly agree plans for how the money will be spent with plans signed off by the relevant local authority and clinical commissioning group(s).

7.3 Under the amended NHS Act 2006, NHS England has the ability to withhold, recover or direct the use of CCG funding where conditions attached to the BCF are not met, except for those amounts paid directly to local government.

7.4 For 2017-19, NHS England require that BCF plans demonstrate how the area will meet the following national conditions:

• Plans to be jointly agreed;

• NHS contribution to adult social care is maintained in line with inflation;

• Agreement to invest in NHS commissioned out-of-hospital services, which may include 7 day services and adult social care; and

• Managing Transfers of Care

7.5 The Improved Better Care Fund Grant determination is made by the Secretary of State under section 31 of the Local Government Act 2003. The grant may be used only for the purposes of meeting adult social care needs; reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready and ensuring that the local social care provider market is supported.

7.6 The Council is required to:

- Pool the grant funding into the local Better Care Fund, unless the authority has written ministerial exemption

- Work with the relevant Clinical Commissioning Group and providers to meet National Condition 4 (Managing Transfers of Care) in the Integration and Better Care Fund Policy Framework and Planning Requirements 2017-19

- Provide quarterly reports as required by the Secretary of State

Non-Applicable Sections:	None.
Background Documents: (Access via Contact Officer)	Improved Better Care Fund (iBCF) Report No. CS18065

Integrated Commissioning Board

Work Programme- December 2017 to April 2019

Update – September 2018

Priority area	Actions	Target date	Update
1 Refresh the JSNA and the Health & Wellbeing Strategy Both documents form the framework for prioritising and shaping joint work programmes to address needs and transform services in Bromley	• Production of the JSNA	Feb 2018	The JSNA has been published and it is available on the LBB website.
	• Evaluation of the JSNA and HWB Strategy development [commencing in Jan 2018]	March 2018	Evaluation completed & presented to the HWB Board in June.
	• HWB Board to agree the process for the HWB Strategy refresh	March –May 2018	Process for updating the Health and Wellbeing Strategy agreed by HWB Board in June.
	• Production of the HWB Strategy	Sept 2018	In progress.
2 Develop an Integration & Transformation Strategy for Bromley Production of the strategy to promote integrated health & care commissioning and services as we progress towards the creation of an Integrated Care System/Partnership	• Case for Change document produced	March '18	Draft 2020 Strategy prepared and scheduled for ICB consideration.
	• Integration Strategy endorsed through appropriate LBB/CCG governance	May '18	In progress – completion rescheduled for December 2018
	• Review of Section 75 agreement	July '18	Section 75 reviewed and updated. Formal approvals/governance in progress
3 Develop Joint Commissioning Strategies	**Phase 1**: Joint strategy for older adults • Production of High level Strategy for endorsement and further engagement • Review integrated model of service required • Review the frailty pathway, including joint approaches to enable people to leave acute care promptly with an appropriate range of intermediate care or longer term services in place. • Review range of provision (including transfer of care	June 18	Development of Bromley 'Ageing Well' Strategy in progress. Extensive programme of public engagement undertaken over the summer '18

Priority area	Actions	Target date	Update
	bureau, discharge to assess, reablement, rehabilitation and intermediate care services) to enable appropriate care pathways for Bromley residents. • Review provision of telehealth and telecare • Finalised Draft Strategy • Strategies endorsed through appropriate LBB/CCG governance	 Dec 18 January 19	Review of relevant service areas undertaken through the summer '18 – for operational delivery through 18/19 and to support longer term strategic development. Draft Strategy to be delivered by January 19 for approval.
	Joint strategy for adult mental health services • Production of High level Strategy for endorsement and further engagement • Finalised Draft Strategy • Strategy endorsed through appropriate LBB/CCG governance	 June 18 Oct 18 Nov 18	The Mental Health Strategic Partnership Board agreed priorities including integrated working and development of Single Point of Access (April '18). Draft strategy currently under review by MH Strategic Partnership Board Formal approvals anticipated November 2018
	Phase 2: • Future programme of integrated strategies to be determined by ICB at Sept meeting	Sept 18	Integrated Learning Disability Strategy in discussion for production by approx. April 19
4 BCF and IBCF – joint management, prioritisation and oversight Both programmes are in support of sustainable service delivery and the transformation of models of care	• Review spend and delivery on BCF to date • Quarterly reporting to NHSE & updates to ICB • Develop proposals for investment of BCF/IBCF against agreed joint priorities for 2018/19;	Quarterly Quarterly From April 18	BCF spend, commitments and delivery regularly reviewed at ICB Quarterly reports completed and reported to H&WB Board BCF investment plan/priorities for 18/19 recommended by ICB for approval.

Priority area	Actions	Target date	Update
5 Develop an integrated commissioning framework Develop systems and processes to integrate performance reporting, outcomes measurement and quality assurance across jointly commissioned services.	• Joint review of contract registers and identification of opportunities for integrated working. • For all (a) jointly commissioned services and (b) services requiring joint contract management, the development of an integrated framework for: • Information exchange • Performance management • Oversight of quality and safety • Agreeing direction of travel for service development • Develop joint arrangements to enable best practice and innovation in service procurement across agencies wherever possible. • Strengthen local arrangements/joint protocols to procure and monitor individual care placements (in or out of borough), sharing resources and expertise across health and social care in an integrated approach.	January '18 April '18 June '18 June '18	LBB and CCG contract registers refreshed and shared. Opportunities for joint approaches to contract management under review. Review of Section 31 underway. LBB Oxleas contract management will be incorporated into the existing CCG Contract Monitoring to become a joint contract management arrangement. Information sharing agreements across the Health and Care economy under review. Bromley Y contract currently jointly monitored
6 Integrated Governance To support the integration of services and delivery of the agreed work programme.	• Review of Governance completed • Deliver new Integrated Commissioning Board • Deliver new Commissioning Network (Delivery Group) • Design and agree ICB work programme for period to April 2019 • Implement agreed work programme and report progress/exceptions at each meeting of ICB.	October '17 December '17 December '17 December '17 Ongoing	LBB & CCG have approved a development programme for Integrated Commissioning (July 2018) – covering scope, governance, leadership and workforce. Development plan in progress.
7 Integrated Information Systems	• Develop the 'digital roadmap' which will enable more effective integrated working and information systems	June '18	The roadmap is in place as part of the SE London STP. LBB working with the CCG and represented on LDR Groups

Priority area	Actions	Target date	Update
8. Special Educational Needs and Disability (SEND): Support multi-agency implementation of SEND reforms Ensure health elements in place and fully operational.	• Appoint to vacant Joint Commissioner – Children/SEND post • Develop/clarify joint commissioning strategy for SEND, including transition to adult services, & secure joint endorsement at ICB • Health – appoint SEND health lead (fixed term) to lead a programme of review and improvement. • Health - implement improvement programme across local NHS organisations to enhance service provision, systems and processes, and readiness for expected SEND inspection.	January '18 June '18 November '17 Nov '17 to Nov '18	Completed Vision and priorities document, with associated work plan agreed. Joint Commissioning strategy In progress Appointed November '17 for 12 months, now extended until March '19. Full time, permanent SEND DCO appointed by the CCG (Sept '18) In progress – action plan in place.
9. Review Children and Mental Health Services (CAMHS) provision	• Co-production of future service model for Tier 2 and Tier 3 • Tier 3 specification • Tier 2 strategy and specification • Plan/implementation of required procurements (e.g.Tier 2) to mobilise services (from July '18)	June '18 June'18 April 19	Insight phase now concluded and progressing co-design of future service model, system and care pathways. Proposing to develop a network/ Alliance model of delivery into 2019. Programme of CAMHS service improvements via investment of transformation funds in progress.
10. Review Speech and Language Therapy (SALT) provision	• Support and enable maintenance of services into schools from 1st December '17 to July '19 via contract agreement with Bromley Healthcare and utilisation of existing and BCF resources in the short term. • Plan and commission appropriate longer term service model for SALT in schools • Procure new service model and implement by September 2019	December '17 to July '19. Sept/Oct '18 Oct '18 to Sept '19	Delivery of service into schools for academic year 2018/19 agreed. Future service model planning, resources and procurement programme in progress for September 2019.

Priority area	Actions	Target date	Update
11. Health capacity and support for Children's services: Clarify requirements and ensure sufficient health capacity available to support child safeguarding, looked after children, fostering and adoption assessment and care planning processes.	• Undertake a review of health capacity and resources directed towards support for child related safeguarding, LAC, panels, assessment and care planning processes. • Report to ICB and implement any agreed changes. • Further review the design and delivery of the LBB commissioned health support to schools service, implementing agreed short-term additional capacity in 2018/19 and bringing forward proposals for maintaining future service coverage & capacity.	May '18 June '18 Progress report – June '18 Future plan – November '18	Ongoing collaboration and joint review to ensure appropriate capacity provided. The proposal for the future of Health Support to Schools service has been developed and is under discussion within the LBB governance process. Executive decision pending.
12. Maintain & extend the Integrated Care Networks (ICNs) ICNs are the focal point for shared service delivery around individual patients by local multi-disciplinary teams	• CCG appoint a permanent Head of Integrated Care Programme Manager • Maintain, develop and performance manage the existing proactive care ICNs, measuring and reporting on: - Impact on emergency admissions (including emergency admissions of clients unknown to MDTs) - Impact on social care packages/costs - Impact on service users signposted to Bromley Well • Develop integrated care/ICNs in the areas of: - Heart failure - Respiratory care - End of life care - Integrated therapies - Care homes (a component of programme 4.1 below) - Learning disabilities	February '18 Review at each ICB Sept 18 onwards	Appointed February '18 Delivery and performance oversight undertaken by the Integrated Care Systems Board Integrated Care Systems work programme broadened to include these areas within 2018/19, but with a priority focus on integrated approaches to enhancing urgent & emergency care services.
13. Progress the development of an Adult Mental Health Services Integrated Care Partnership To integrate health, social care & wellbeing services	• Consider potential for a MH Integrated Care System at Mental Health Strategy Board. • Establish a multi-agency task and finish group to scope potential for MH ACP. • Draft proposals to MH Strategy Board & ICB • Organisational governance processes	January '18 May '18 June/July '18 From Sept '18	The Mental Health Strategic Partnership Board held a workshop on 24th April to consider Integrated care opportunity. Agreed to include MH in Integrated Care priorities/work programme and to prioritise work on the Single Point of Access model. Links to development of MH

Priority area	Actions	Target date	Update
	• Commence implementation of ACP for MH		strategy (item 3, above).
14. Deliver the Discharge to Assess (D2A) Pilot	• Deliver pilot and assess impact • Produce recommendations and report to ICB for future discharge model	April '18	Pilot delivered (17/18). Performance reviewed and continuation of the initiative for 2018/19 agreed. Multi-agency Programme Board established to oversee progress and performance.
15. Support a review of Occupational Therapy services	• Prioritise initiatives to ensure sufficient capacity to meet demand within social care/LBB and to address length of waits/backlog • Scope strategic opportunities for an integrated OT service across health & social care.	Nov'17 – Feb '18 April-June '18	Internal LBB review completed. Proposal in development following completion of LBB internal review
16. Domiciliary Care Commissioning	• LBB strategic commissioning review of Dom Care to commence February 18 – to incorporate • Joint review of market capacity across LBB and CCG • Exploration of joint commissioning • Development of joint market management arrangements regardless of whether joint commissioning undertaken • Governance/decision making	February – Sept 18 October 18 onwards	LBB contract extended until August 2021. New LBB/CCG strategic board meeting on19/9/18. Service design finalised by June 19 Tendering new model from July 19

Priority area	Actions	Target date	Update
17. Care Homes	• Establish a joint Programme Board and work streams to support Care Homes initiative • Workstream leads to develop programme of activity and milestones for Board discussion and approval Work Stream 1 – Strategy • Develop a joint commissioning strategy for services from care homes based on a clear assessment of future needs, capacity requirements and identification of barriers to change and innovation • Joint review of market capacity and development of joint market management arrangements. • Integrated approach to Market Position Statements for frail elderly care Work Stream 2 – Health and Social Care Offer • Determine the model health and social care offer to care homes in the borough, built around 3 local networks of multidisciplinary support, advice and care - to include primary medical services and medicines management. • Work with care homes to enable people to receive managed care in their home environment, to include end of life care, reducing the number of inappropriate emergency admissions to hospital. Work Stream 3 – Quality • Develop and implement a joint approach to quality and safety within care homes to enable a consistent standard of service provision. to include workforce development, training and support programmes, robust safeguarding practices, and quality measurement and improvement	Nov '17 March '18	Care Homes Programme Board established. Workstreams & lead roles established. Programme Manager jointly appointed. Programme of activity in place. Reviewing CCG and LBB placements. Exploring options for collaboration in market management and procurement. 3 workshops on requirements of health and care offer to care homes held; Future service specification in draft – for completion in November '18 New model of GP commissioned support to care homes in procurement. A joint health and social care quality framework being piloted on a collaborative basis
18. Explore business case for procurement of a nursing home in the Borough with full nomination rights for the Council.	• Development of business case to determine whether to proceed with consideration of capital investment • Options appraisal (dependent upon business case)	April '18 July 18	Business case produced for discussion with Portfolio Holder (Sept 18). Report under consideration at present.

Priority area	Actions	Target date	Update
19. Promote and extend the scope and take up of direct payments (LBB) and personal health budgets (CCG).	• Review of opportunities for integrated systems and processes to support both DPs and PHBs • Health: scope programme of work to broaden PHB offer to wider group of patients and achieve CCG targets	April 18 May '18	In progress – CCG rep now established on Direct Payments project. CCG Personalised Commissioning framework under development.
20. Collaborate on the Transforming Care Programme, ensuring an appropriate range of services are commissioned to meet the identified needs of people with learning disabilities within the borough, including placements outside the NHS.	• Produce update of activity and plans for 18/19 • Continue to actively case manage individual clients with TCP, enabling individuals to be appropriately supported outside NHS facilities where possible • Collaborate with health & social care commissioners in SEL to develop joint proposals for local specialist/health provision to prevent out of area placements where possible.	June ICB meeting Ongoing work	TCP initiatives ongoing. Integrated LD Strategy in consideration for production by Q1 19/20. Engagement with SEL STP developing proposals for future local service options.

Ref: GM/PF – Update Sept.18

Report No.
CSD18124

London Borough of Bromley

Decision Maker:	**HEALTH AND WELLBEING BOARD**
Date:	**Thursday 19th July 2018**
Decision Type:	Non Urgent Non-Executive Non-Key
Title:	**MATTERS ARISING AND WORK PROGRAMME**
Contact Officer:	Kerry Nicholls, Democratic Services Officer Tel: 0208 313 4602 E-mail kerry.nicholls@bromley.gov.uk
Chief Officer:	Mark Bowen, Director of Corporate Services
Ward:	N/A

1. Reason for report

1.1 The Health and Wellbeing Board is asked to review its Work Programme and to consider progress on matters arising from previous meetings of the Board.

2. RECOMMENDATION

2.1 The Health and Wellbeing Board is requested to:

1) **Review its Work Programme; and,**

2) **Consider matters arising from previous meetings, indicating any changes required.**

Impact on Vulnerable Adults and Children

1. Summary of Impact: Not Applicable

Corporate Policy

1. Policy Status: Existing Policy: As part of the Excellent Council workstream within Building a Better Bromley, the Health and Wellbeing Board should plan and prioritise its workload to achieve the most effective outcomes.
2. BBB Priority: Excellent Council

Financial

1. Cost of proposal: No Cost
2. Ongoing costs: Not Applicable
3. Budget head/performance centre: Democratic Services
4. Total current budget for this head: £350,650
5. Source of funding: 2018/19 revenue budget

Staff

1. Number of staff (current and additional): 8 posts (6.87 fte)
2. If from existing staff resources, number of staff hours: Maintaining the Board's work programme takes less than an hour per meeting

---

Legal

1. Legal Requirement: None.
2. Call-in: Not Applicable. This report does not involve 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 the benefit of members of this Board to use in controlling their 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 Matters Arising table updates Board Members on “live” matters arising from previous meetings wand is attached at **Appendix 1**.

3.2 The Health and Wellbeing Board’s Work Programme is attached at **Appendix 2**. Meetings are scheduled to be held approximately two weeks after Bromley Clinical Commissioning Group Board meetings to facilitate the feedback mechanism from the Bromley Clinical Commissioning Group to the Health and Wellbeing Board. In approving the Work Programme, Board Members will need to be satisfied that priority issues are being addressed in line with the priorities set out in the Board’s Health and Wellbeing Strategy and Terms of Reference which were approved by Council in April 2013.

3.3 Dates of Meetings and report deadline dates are provided at **Appendix 3**.

3.4 The Constitution of the Health and Wellbeing Board is provided at **Appendix 4**.

3.5 The updated Glossary is provided at **Appendix 5**.

Non-Applicable Sections:	Impact on Vulnerable Adults and Children and Policy/Financial/Legal/Personnel Implications
Background Documents:	Previous matters arising reports and minutes of meetings.

APPENDIX 1

Health and Wellbeing Board: Matters Arising/Action List

Agenda Item	Action	Officer	Notes	Status
Minute 27 19th July 2018 Better Care Fund 2017/18 – Q4 Performance Update	It was requested that revised performance data for Bromley Well for the period of October 2017 to March 2018 (included in the report at Paragraph 4.29) be provided to Board Members following the meeting.	**Kerry Nicholls**	This information was provided to the Health and Wellbeing Board following the meeting.	**Completed**
Minute 22 19th July 2018 Falls Prevention System Review: Final Report and Recommendations	The Programme Director: Integrated Care Services, Bromley Clinical Commissioning Group agreed to act as Lead Officer for the Falls Prevention workstream, and that regular updates on the implementation of the recommendations of the Falls Task and Finish Group would be provided to the Board.	**Mark Cheung**	Regular updates had been built into the Health and Wellbeing Board Work Programme, including written updates scheduled for 6 and 12 months.	**Completed**
Minute 21 19th July 2018 Mytime Active: Health and Wellbeing Initiatives	Members requested that the Communications Executive review how the activities of Mytime Active were highlighted to residents	**Susie Clark**	A communications update would be provided to the next meeting of Health and Wellbeing Board on 27th September 2018.	**Completed**
Minute 59 29th March 2018 Minutes of the Previous Meeting	The Chairman agreed to hold discussions with Mr Ashish Desai, Consultant Paediatric Surgeon regarding work being undertaken by King's College Hospital NHS Foundation Trust in relation to childhood obesity.	**Councillor David Jefferys**	The Chairman had arranged a meeting with Mr Ashish Desai in August 2018 and would report the outcome to Board Members at the next meeting of the Health and Wellbeing Board.	**In progress**
Minute 10 7th September 2017 Delayed Transfer of Care Performance	Members resolved that the Health and Wellbeing Board receive regular updates on Delayed Transfer of Care performance locally and progress made against plans to reduce delayed transfers	**Ade Adetosoye/ Jodie Adkin/ Dr Bhan**	This has been noted and the matter has been factored into the work plan and future agendas.	**Ongoing**

APPENDIX 2

HEALTH AND WELLBEING BOARD
WORK PROGRAMME

28th November 2018	
Better Care Fund and Improved Better Care Fund Performance Update	Jackie Goad
Bromley Communications and Engagement Network – Activity Report	Susie Clark
Health Support to School Age Children	Dr Jenny Selway
Bromley Safeguarding Adults Board Annual Report	Lynn Sellwood
Bromley Safeguarding Children Board Annual Report	Jim Gamble/Joanna Gambhir
Update on DToC Performance	Jodie Adkin/Ade Adetosoye
Social Isolation - Update on Local and National Initiatives	Denise Mantell
Engagement Outcomes towards the Forthcoming Strategy for Older People and those approaching Old Age	Denise Mantell
Joint Strategy for Ageing Well in Bromley	Mark Davison
Verbal Update on Implementation of the Recommendations of the Falls Task and Finish Group	Dr Angela Bhan/Mark Cheung
Work Programme and Matters Arising	Kerry Nicholls
31st January 2019	
Better Care Fund and Improved Better Care Fund Performance Update	Jackie Goad
Chairman's Annual Report	Councillor David Jefferys
Primary Care Commissioning Update	Dr Angela Bhan/Dr Andrew Parson
Update on DToC Performance	Jodie Adkin/Ade Adetosoye
Written Update on Implementation of the Recommendations of the Falls Task and Finish Group	Dr Angela Bhan/Mark Cheung
Work Programme and Matters Arising	Kerry Nicholls
21st March 2019	
Better Care Fund and Improved Better Care Fund Performance Update	Jackie Goad
Healthy Weight Bromley: Children and Young People Update	Dr Nada Lemic
Update on DToC Performance	Jodie Adkin/Ade Adetosoye
Update on Infant Mortality Rate in Bromley	Dr Jenny Selway
Integrated Commissioning Board Update	Graham Mackenzie/Paul Feven
Information Item: Guide for Schools on the Month of Ramadan and Fasting (referral from SACRE)	Dr Omar Taha
Verbal Update on Implementation of the Recommendations of the Falls Task and Finish Group	Dr Angela Bhan/Mark Cheung
Work Programme and Matters Arising	Kerry Nicholls

Unprogrammed Outstanding Items:
Developing a System Wide Mental Health Strategy/Mental Health Act (Harvey Guntrip)
Update on Childhood Obesity Work by King's College Hospital NHS Foundation Trust (Chairman)
Mental Health Strategic Partnership Update (Harvey Guntrip)
Elective Orthopaedic Centres (CCG)
Implementation of Personal Health Budgets (LBB)
Improvements in Services for Dementia Suffers (LBB/CCG)
FGM Update (Mimi Morris-Cotterill)

APPENDIX 3

DATES OF MEETINGS AND REPORT DEADLINE DATES

The Agenda for meetings MUST be published five clear days before the meeting.

Report Deadlines are the final date by which the report can be submitted to Democratic Services. Report Authors will need to ensure that their report has been signed off by the relevant chief officers before submission.

Date of Meeting	Report Deadline (3.00pm)	Agenda Published
Thursday 7th June 2018	Tuesday 29th May 2018	Wednesday 30th May 2018
Thursday 19th July 2018	Tuesday 10th July 2018	Wednesday 11th July 2018
Thursday 27th September 2018	Tuesday 18th September 2018	Wednesday 19th September 2018
Wednesday 28th November 2018	Monday 18th November 2018	Tuesday 20th November 2018
Thursday 31st January 2019	Tuesday 22nd January 2019	Wednesday 23rd January 2019
Thursday 21st March 2019	Tuesday 12th March 2019	Wednesday 13th March 2019

A link to the agenda is emailed to the Board on the publication date. Hard copies are available on request.

Questions
Questions from members of the public to the meeting will be referred directly to the relevant policy development and scrutiny (PDS) committee of the Council, or to other meetings as appropriate, at the next available opportunity unless they relate directly to the work of the Board.

A list of the questions and answers will be appended to the corresponding minutes.

Minutes
The minutes are drafted as soon as possible after the meeting has finished. They are then sent to officers for checking. Once any amendments have been made, they are sent to the Chairman, and once he has cleared them, they are sent, in draft format, to Members of the board. Please note that this process can take up to two weeks.

The draft minutes are then incorporated on the agenda for the following meeting and are confirmed.

APPENDIX 4

LONDON BOROUGH OF BROMLEY
HEALTH & WELLBEING BOARD

Constitution

(11 Elected Members, including one representative from each of the two Opposition Parties; the two statutory Chief Officers (without voting rights); two representatives from the Clinical Commissioning Group (with voting rights); a Health Watch representative (with voting rights) and a representative from the Voluntary Sector (with voting rights). The Chairman of the Board will be an Elected Member appointed by the Leader. The quorum is one-third of Members of the Board providing that elected Members represent at least one half of those present. Substitution is permitted. Other members without voting rights can be co-opted as necessary.

1. Providing borough-wide strategic leadership to public health, health commissioning and adults and children's social care commissioning, acting as a focal point for determining and agreeing health and wellbeing outcomes and resolving any related conflicts.

2. Commissioning and publishing the Joint Strategic Needs Assessment (JSNA) under the Health and Social Care Act.

3. Commissioning and publishing a Joint Health & Wellbeing Strategy (JHWS) – a high level strategic plan that identifies, from the JSNA and the national outcomes frameworks, needs and priority outcomes across the local population, which it will expect to see, reflected in local commissioning plans.

4. Receiving the annual CCG commissioning plan for comment, with the reserved powers to refer the CCG commissioning plan to the NHS Commissioning Board should it not address sufficiently the priorities given by the JSNA.

5. Holding to account all areas of the Council, and other stakeholders as appropriate, to ensure their annual plans reflect the priorities identified within the JSNA.

6. Supporting joint commissioning and pooled budget arrangements where it is agreed by the Board that this is appropriate.

7. Promoting integration and joint working in health and social care across the borough.

8. Involving users and the public, including to communicate and explain the JHWS to local organisations and residents.

9. Monitor the outcomes and goals set out in the JHWS and use its authority to ensure that the public health, health commissioning and adults and children's commissioning and delivery plans of member organisations accurately reflect the Strategy and are integrated across the Borough.

10. Undertaking and overseeing mandatory duties on behalf of the Secretary of State for Health and given to Health and Wellbeing Boards as required by Parliament.

11. Other such functions as may be delegated to the Board by the Council or Executive as appropriate.

APPENDIX 5

GLOSSARY OF ABBREVIATIONS – HEALTH & WELLBEING BOARD

Acute Treatment Unit	(ATU)
Antiretroviral therapy	(ART)
Any Qualified Provider	(AQP)
Autistic Spectrum Disorders	(ASD)
Behaviour, Attitude, Skills and Knowledge	(BASK)
Better Care Fund	(BCF)
Black African	(BA)
Body Mass Index	(BMI)
British HIV Association	(BHIVA)
Bromley Clinical Commissioning Group	(BCCG)
Bromley Safeguarding Children Board	(BSCB)
Cardiovascular Disease	(CVD)
Care Programme Approach	(CPA)
Care Quality Commission	(CQC)
Children & Adolescent Mental Health Service	(CAMHS)
Child Sexual Exploitation	(CSE)
Chlamydia Testing Activity Dataset	(CTAD)
Clinical Commissioning Group	(CCG)
Clinical Decision Unit	(CDU)
Clinical Executive Group	(CEG)
Clinical Leadership Groups	(CLG)
Common Assessment Framework	(CAF)
Community Learning Disability Team	(CLDT)
Community Psychological Services	(CPS)
Delayed Transfer of Care	(DTOC)
Director of Adult Social Services	(DASS)
Director of Children's Services	(DCS)
Disability Discrimination Act 1995	(DDA)
Dispensing Appliance Contractors	(DAC)
Emergency Hormonal Contraception	(EHC)
Essential Small Pharmacy Local Pharmaceutical Services	(ESPLPS)
Female Genital Mutilation	(FGM)
Florence – telehealth system using SMS messaging	(FLO)
Health & Wellbeing Board	(HWB)
Health & Wellbeing Strategy	(HWS)
Health of the Nation Outcome Scales	(HoNOS)
Hypertension Action Group	(HAG)
Improved Better Care Fund	(IBCF)
Improving Access to Psychological Therapies programme	(IAPT)
Improvement Assessment Framework	(IAF)
In Depth Review	(IDR)
Integrated Care Network	(ICN)
Integration Transformation Fund	(ITF)
Intensive Support Unit	(ISU)
Joint Health & Wellbeing Strategy	(JHWS)
Joint Integrated Commissioning Executive	(JICE)
Joint Strategic Needs Assessment	(JSNA)
Kings College Hospital	(KCH)
Local Medical Committee	(LMC)
Local Pharmaceutical Committee	(LPC)

Local Pharmaceutical Services	(LPS)
Local Safeguarding Children's Boards	(LSCB)
Long Acting Reversible Contraception	(LARC)
Mental Health Champion	(MHC)
Multi Agency Planning	(MAP)
Medicines Adherence Support Service	(MASS)
Medicines Adherence Support Team	(MAST)
Medium Super Output Areas	(MSOAs)
Men infected through sex with men	(MSM)
Mother to child transmission	(MTCT)
Multi-Agency Safeguarding Hubs	(MASH)
Multi-Agency Sexual Exploitation	(MASE)
National Chlamydia Screening Programme	(NCSP)
National Institute for Clinical Excellence	(NICE)
Nicotine Replacement Therapies	(NRT)
National Reporting and Learning Service	(NRLS)
Nucleic acid amplification tests	(NATTS)
Patient Liaison Officer	(PLO)
People living with HIV	(PLHIV)
Pharmaceutical Needs Assessment	(PNA)
Policy Development & Scrutiny committee	(PDS)
Primary Care Trust	(PCT)
Princess Royal University Hospital	(PRUH)
Proactive Management of Integrated Services for the Elderly	(ProMISE)
Public Health England	(PHE)
Public Health Outcome Framework	(PHOF)
Quality and Outcomes Framework	(QOF)
Quality, Innovation, Productivity and Prevention programme	(QIPP)
Queen Mary's, Sidcup	(QMS)
Speech and Language Therapy	(SALT) or (SLT)
Secure Treatment Unit	(STU)
Serious Case Review	(SCR)
Sex and Relationship Education	(SRE)
Sexually transmitted infections	(STIs)
South London Healthcare Trust	(SLHT)
Special Educational Needs	(SEN)
Summary Care Record	(SCR)
Supported Improvement Adviser	(SIA)
Sustainability and Transformation Plans	(STP)
Tailored Dispensing Service	(TDS)
Unitary Tract Infections	(UTI)
Urgent Care Centre	(UCC)
Voluntary Sector Strategic network	(VSSN)
Winterbourne View Joint Improvement Programme	(WVJIP)

This page is left intentionally blank