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: 9 October 2018

To: Members of the
HEALTH SCRUTINY SUB-COMMITTEE

Councillor Mary Cooke (Chairman)
Councillor Robert Mcilveen (Vice-Chairman)
Councillors Gareth Allatt, Aisha Cuthbert, Ian Dunn, Judi Ellis, Robert Evans, David Jefferys and Angela Page

Non-Voting Co-opted Members

Roger Chant, Bromley Carer
Justine Godbeer, Bromley Experts by Experience
Lynn Sellwood, Bromley Safeguarding Adults Board and Voluntary Sector Strategic Network
Tim Spilsbury, Healthwatch Bromley

A meeting of the Health Scrutiny Sub-Committee will be held at Bromley Civic Centre on **WEDNESDAY 17 OCTOBER 2018 AT 4.00 PM**

MARK BOWEN
Director of Corporate Services

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

A G E N D A

1 APOLOGIES FOR ABSENCE AND NOTIFICATION OF SUBSTITUTE MEMBERS

2 DECLARATIONS OF INTEREST

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

In accordance with the Council's Constitution, questions to this Committee must be received in writing 4 working days before the date of the meeting. Therefore please ensure questions are received by the Democratic Services Team by 5pm on Thursday 11th October 2018

4 MINUTES OF THE MEETINGS OF HEALTH SCRUTINY SUB-COMMITTEE HELD ON 11TH AND 30TH JULY 2018 AND MATTERS ARISING (Pages 3 - 14)

5 VERBAL UPDATE ON PRUH LEADERSHIP RECRUITMENT (KING'S)

6 PRUH IMPROVEMENT PLAN - UPDATE FROM KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST (KING'S)

7 ORPINGTON HOSPITAL UPDATE (KING'S)

8 INPATIENT NUTRITION AND HYDRATION UPDATE (KING'S)

9 BROMLEY HEALTH AND WELLBEING CENTRE PROJECT: UPDATE AND PROGRESS REPORT (CCG) (Pages 15 - 20)

10 BROMLEY MINOR EYE CONDITIONS SERVICE PILOT UPDATE (CCG) (Pages 21 - 70)

11 WINTER PLANNING (CCG) (Pages 71 - 106)

Please be advised that this agenda item only includes selected appendices from the Winter Plan.

The Winter Plan with all appendices can be viewed in the agenda for Health and Wellbeing Board on 27th September 2018 accessible via this link:

https://cds.bromley.gov.uk/ieListDocuments.aspx?CId=617&MId=6344&Ver=4

12 JOINT HEALTH SCRUTINY COMMITTEE VERBAL UPDATE (JHOSC REPRESENTATIVES)

13 WORK PROGRAMME 2018/19 (Pages 107 - 110)

14 ANY OTHER BUSINESS

15 FUTURE MEETING DATES

4.00pm, Wednesday 16th January 2019
4.00pm, Wednesday 3rd April 2019

HEALTH SCRUTINY SUB-COMMITTEE

Minutes of the meeting held at 4.00 pm on 11 July 2018

Present:

Councillor Mary Cooke (Chairman)
Councillor Robert Mcilveen (Vice-Chairman)
Councillors Gareth Allatt, Aisha Cuthbert, Robert Evans and Angela Page

Stephanie Wood

Also Present:

Councillor Diane Smith, Portfolio Holder for Adult Care and Health
Councillor Yvonne Bear

1 APOLOGIES FOR ABSENCE AND NOTIFICATION OF SUBSTITUTE MEMBERS

Apologies for absence were received from Councillor Ian Dunn, Councillor Judi Ellis, Councillor David Jefferys, Lynn Sellwood and Justine Godbeer.

Apologies for absence were also received from Tim Spilsbury, and Stephanie Wood attended as his substitute.

Apologies for lateness were received from Councillor Aisha Cuthbert.

2 DECLARATIONS OF INTEREST

Councillor Mary Cooke declared that she was a former employee of Bromley Healthcare and had left the organisation in 2012.

Councillor Yvonne Bear declared that she was a member of the Council of Governors for Oxleas NHS Foundation Trust representing the Local Authority.

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

No questions had been received.

4 MINUTES OF THE MEETING OF HEALTH SCRUTINY SUB-COMMITTEE HELD ON 6TH MARCH 2018 AND MATTERS ARISING

RESOLVED that the minutes of the meeting held on 6th March 2018 be agreed.

5 REABLEMENT WORKSTREAM WITHIN BROMLEY ADULT AND OLDER PEOPLE'S MENTAL HEALTH DIRECTORATE (OXLEAS NHS FOUNDATION TRUST)

The Sub-Committee received a presentation from Estelle Frost, Service Director, Bromley Adult Mental Health Services, Adrian Dorney, Associate Director, Inpatient and Crisis Services, Donvé Thompson-Boy, Lead Occupational Therapist and Pauline Kenny, Mental Health Service Manager, Oxleas NHS Foundation Trust on the Reablement workstream within Bromley Adult and Older People's Mental Health Directorate. Councillor Yvonne Bear, a member of the Council of Governors for Oxleas NHS Foundation Trust representing the Local Authority was also in attendance.

The Reablement workstream had been developed after it was identified that there was a lack of reablement support available to patients with mental health needs admitted to hospital for physical health issues following their discharge. This included the establishment of a Pathway which supported partners to work collaboratively in completing a rigorous assessment of needs and a discharge planning process for each patient, and also offered increased availability to Reablement and Transfer of Care Bureau resources. Further work being undertaken in this area included a review of access to Extra Care Housing, mental health awareness training for domiciliary care workers, and joint Transfer of Care Bureau and Oxleas NHS Foundation Trust briefings to promote cross-working and improve access to care.

In considering the Reablement workstream, the Chairman was pleased to note that patients' needs were being treated more holistically. The Vice-Chairman underlined that this should include the physical, mental and social care needs of patients with mental health needs who had been discharged from hospital. The Associate Director, Inpatient and Crisis Services reported that key partners were working increasingly closer together to ensure that comprehensive packages of care were in place to meet the individual needs of people with mental health needs. The Interim Director: Programmes noted that the Local Authority and Bromley Clinical Commissioning Group were also working together to develop integrated strategies on 'Ageing Well' and 'Adult Mental Health' that would identify the longer term vision for these key areas of service provision. A report on the Adult Mental Health Strategy would be presented to Health Scrutiny Sub-Committee at its meeting on 16th January 2019.

In response to a question from a Member, the Associate Director, Inpatient and Crisis Services confirmed that there was a need to consider how people with mental health needs who did not meet the threshold for services could access appropriate support. Oxleas NHS Foundation Trust was working to review the therapeutic interventions available across the Pathway, with a view to establishing a number of Service User Network Groups which offered ongoing support to people with mental health needs and could be accessed without a referral.

The Chairman led the Sub-Committee in thanking Estelle Frost, Adrian Dorney and Donvé Thompson-Boy for their excellent presentation which is attached at Appendix A.

RESOLVED that the presentation be noted.

6 BROMLEY HEALTHCARE QUALITY ACCOUNT 2017/18 (BROMLEY HEALTHCARE)

Jacqui Scott, Chief Executive Officer and Janet Ettridge, Director: Operations, Bromley Healthcare presented the Bromley Healthcare Quality Account 2017/18 to the Sub-Committee, which outlined the findings of a review into the quality priorities and performance during 2017/18, and looked forward to a planned improvement in the quality of services across five priority areas for 2018/19. There was a statutory requirement for all NHS publicly funded bodies to provide their Annual Quality accounts to NHS England and for this to contain a supporting statement from the Health Scrutiny Sub-Committee.

During 2017/18, Bromley Healthcare had launched the Care Coordination Centre which went live on 1st January 2018 and offered a single point of access for all patients, carers and referrers into community services, proactively supporting the management of 25,000 Bromley Healthcare patients. Significant progress had also been made in achieving Bromley Healthcare's quality objectives including a 59% reduction in avoidable pressure ulcers, enhanced clinical record sharing with Bromley General Practitioners and implementation of Therapy Outcomes Measures. The National Audit of Intermediate Care had highlighted Bromley Healthcare's Rehabilitation Service as delivering some of the best outcomes for patients both regionally and nationally, and 98.14% of patients responding to the National Friends and Family test had stated they were 'Likely' or 'Extremely Likely' to recommend Bromley Healthcare's services. A number of innovative outcome-based contracts commissioned by the Bromley Clinical Commissioning Group had also been successfully implemented. Five priority areas had been identified for improvement for 2018/19 which reflected learning from Care Quality Commission (CQC) inspections undertaken since 2016/17 and were underpinned by the five CQC core standards for a healthcare organisation comprising Safe, Caring, Responsive, Effective and Well Led. This would include a focus on Bromley Healthcare staff following a significant period of change.

In considering the quality priorities for 2018/19, the Chief Executive Officer, Bromley Healthcare confirmed that the target of 3% for patient engagement was one of the measures by which Bromley Healthcare aimed to place patients at the centre of their care, and would be achieved by encouraging patients to provide feedback relating to their patient experience. A Member queried the total direct cost per service user assessed by Bromley Healthcare which, at £175 per user appeared to be considerably more cost effective than the London and England average costs, and the Chief Executive Officer, Bromley Healthcare would provide further details to Members following the meeting.

In response to a series of questions from Members, the Chief Executive Officer, Bromley Healthcare advised that recruitment continued to be a concern in some areas of service provision but that work was underway to embed robust recruitment and retention practices across Bromley Healthcare and reduce the use of bank and agency staff, which had already proved effective for service areas such as the Rapid Response Team which was now fully-staffed. Bromley Healthcare was currently developing a sustainable response to ongoing recruitment difficulties within the District Nursing service which had included a highly successful open day for newly qualified nurses and the introduction of nursing associate apprenticeships to encourage young people to build a career in the service. Apprenticeships would be a key part of the future recruitment strategy of Bromley Healthcare, with four apprentices already placed within the Care Coordination Centre and plans to introduce further nursing associate apprenticeship opportunities across wider health and care services. Consideration was being given to whether the high cost of housing in the London Borough of Bromley was affecting recruitment and retention and how this might be addressed, such as by promoting key worker housing schemes.

The Interim Director: Programmes highlighted the Proactive Care Pathway, which had been developed by Bromley Clinical Commissioning Group with a range of partners including Bromley Healthcare, as an example of best practice. Delivered as part of the Bromley Out of Hospital Transformation Strategy, the Pathway had provided proactive, coordinated care to over 1600 patients since the launch of the scheme which aimed to support the health and care needs of service users through integrated services, reducing unnecessary emergency admission in the system. The Chief Executive Officer, Bromley Healthcare confirmed that Care Navigators were now based with the three Integrated Care Networks and worked to assist patients and carers with identifying and accessing the systems and support available to meet their individual care needs.

A Co-opted Member suggested that Bromley Healthcare attend a future meeting of the Health Scrutiny Sub-Committee to provide an update on the outcomes of the Care Coordination Centre. The Chairman suggested that it might also be useful to arrange a Member visit to the Centre.

The Chairman led Members in thanking Bromley Healthcare for an excellent report and was pleased to note that patient experience had been placed at the heart of the Bromley Healthcare Quality Account 2017/18.

RESOLVED that the Bromley Healthcare Quality Account 2017/18 be supported by the Health Scrutiny Sub-Committee.

7 PRUH IMPROVEMENT PLAN - UPDATE FROM KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST (KING'S)

The presentation was withdrawn.

Dr Angela Bhan, Managing Director, Bromley Clinical Commissioning Group gave a brief verbal update, advising Members that Matthew Trainer, Managing Director, Princess Royal University Hospital had recently been appointed as Chief Executive to Oxleas NHS Foundation Trust, and would be taking up his new role in Autumn 2018.

In discussion, Members generally agreed the importance of ensuring robust leadership and management processes were maintained at the Princess Royal University Hospital at both an operational and strategic level following the Managing Director's departure. A Member suggested that the Chairman write a letter to Ian Smith, Interim Chairman, King's College Hospital NHS Foundation Trust on behalf of the Health Scrutiny Sub-Committee emphasising the need for the right measures to be put in place to ensure the continued delivery of the Princess Royal University Hospital Improvement Plan.

The Chairman requested that the Managing Director, Bromley Clinical Commissioning Group present an update on leadership and management at the Princess Royal University Hospital to the next meeting of the Sub-Committee on 17th October 2018, and that this include a briefing paper.

RESOLVED that the update be noted.

8 EVALUATION OF WINTER SERVICES (CCG)

Dr Angela Bhan, Managing Director, 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 response to a question from the Vice-Chairman, the Managing Director, Bromley Clinical Commissioning Group explained that winter services tended to run until the end of April each year, after which planning could begin for the next winter period. There was limited capacity to begin planning for the next winter period whilst winter services were still being provided; however the Bromley Clinical Commissioning Group recognised the value of earlier planning and mobilisation for some schemes to ensure that staff recruitment processes were completed in good time. Annual leave was managed carefully during periods of high seasonal demand, and work continued across the National Health Service to move towards a seven-day service. A Co-opted Member underlined the value of the increased GP Access Hubs scheme in providing 800 additional General Practitioner appointments per week during Winter 2017/18, and the Managing Director, Bromley Clinical Commissioning Group confirmed that this scheme had been highly successful and that it was planned to commission a similar scheme for Winter 2018/19.

The Interim Director: Programmes noted that the Local Authority and Bromley Clinical Commissioning Group continued to work collaboratively in developing a long term commissioning approach for key services within the care pathway. New service delivery models were being developed for services such as domiciliary care, and these would be designed to deliver enhanced and additional capacity for the winter period.

RESOLVED that the update be noted.

9 JOINT HEALTH SCRUTINY COMMITTEE VERBAL UPDATE (JHOSC MEMBERS)

The Sub-Committee considered the minutes of the meeting of Our Healthier South East London – Joint Health Overview and Scrutiny Committee held on 12th March 2018, at which a finance briefing on King's College Hospital NHS Foundation Trust and the outcome of the Kent and Medway Stroke Service Consultation had been discussed.

RESOLVED that the update be noted.

10 WORK PROGRAMME 2018/19

Report CSD18073

Members considered the forward rolling work programme for the Health Scrutiny Sub-Committee.

The Portfolio Holder for Adult Care and Health requested that King's College Hospital NHS Foundation Trust be invited to present an update on inpatient nutrition and hydration to the next meeting of Health Scrutiny Sub-Committee on 17th October 2018, and that this update include representation from nursing staff and a dietician.

The Chairman invited Members of the Sub-Committee to provide details of any other items they wished to discuss at future meetings to the Clerk to the Committee.

RESOLVED that the work programme be noted.

11 ANY OTHER BUSINESS

Dr Angela Bhan, Managing Director, Bromley Clinical Commissioning Group advised Members that work on the Bromley Health and Wellbeing Centre project was ongoing. The establishment of a third Health Centre within the Borough to complement the Beckenham Beacon and the Orpington Health and Wellbeing Centre was one of the key proposals of the Bromley Out of Hospital Transformation Strategy, which had been developed jointly by the Bromley Clinical Commissioning Group and the Local Authority.

It was planned that the Bromley Health and Wellbeing Centre would be one of three 'hubs' underpinning the new Integrated Care Networks and would play a key role in providing coordinated care to approximately 100,000 people via integrated services, as well as offering primary care services for Bromley residents including a Primary Care Access Hub and the relocation of the Dysart Medical Practice. A preferred site for the development had been identified in the Bromley area and a planning application would be submitted in Autumn 2018.

RESOLVED that the update be noted.

12 FUTURE MEETING DATES

The next meeting of Health Scrutiny Sub-Committee would be held at 4.00pm on Wednesday 17th October 2018.

In response to a question from a Member, the Chairman confirmed that Health Scrutiny Sub-Committee meetings had been scheduled to take place at 4.00pm to maximise attendance by health partners. The Chairman suggested that it might be possible to schedule Health Scrutiny Sub-Committee meetings to take place on the same day as Adult Care and Health PDS Committee meetings, but this was not generally supported by Members.

The Meeting ended at 5.36 pm

Chairman

This page is left intentionally blank

HEALTH SCRUTINY SUB-COMMITTEE

Minutes of the meeting held at 4.00 pm on 30 July 2018

Present:

Councillor Mary Cooke (Chairman)
Councillor Robert Mcilveen (Vice-Chairman)
Councillors Judi Ellis, Robert Evans, Keith Onslow, Angela Page and Angela Wilkins

Lynn Sellwood and Stephanie Wood

Also Present:

Councillor Diane Smith, Portfolio Holder for Adult Care and Health

Councillors Mike Botting and Colin Smith

13 APOLOGIES FOR ABSENCE AND NOTIFICATION OF SUBSTITUTE MEMBERS

Apologies for absence were received from Councillor Gareth Allatt, Councillor Ian Dunn and Tim Spilsbury, and Councillor Keith Onslow, Councillor Angela Wilkins and Stephanie Wood attended as their respective substitutes.

Apologies for absence were also received from Councillor David Jefferys and Justine Godbeer.

14 DECLARATIONS OF INTEREST

There were no declarations of interest.

15 VERBAL UPDATE: MANAGEMENT STRUCTURE OF PRUH AND OTHER BROMLEY SITES BY KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST

Peter Herring, Chief Executive, Dr Shelley Dolan, Chief Operating Officer, Chief Nurse and Executive Director: Midwifery, Matthew Trainer, Managing Director: Princess Royal University Hospital, King's College Hospital NHS Foundation Trust and Dr Angela Bhan, Managing Director: Bromley Clinical Commissioning Group gave a verbal update on the management structure of the Princess Royal University Hospital and other Bromley sites.

The Chief Operating Officer, Chief Nurse and Executive Director: Midwifery confirmed that the current Managing Director: Princess Royal University Hospital would be leaving King's College Hospital NHS Foundation Trust in September 2018. Laura Badley, Deputy Director: Operations, Networked Care at King's College Hospital NHS Foundation Trust had recently been

appointed Interim Managing Director: Princess Royal University Hospital for a period of six months and was working alongside the departing Managing Director to ensure a smooth management transition. Work was underway to recruit a permanent Managing Director: Princess Royal University Hospital and several high quality candidates had expressed interest in the opportunity.

The Chairman led Members in thanking Peter Herring, Dr Shelley Dolan, Matthew Trainer and Dr Angela Bhan for their verbal update and congratulated Matthew Trainer on his appointment as Chief Executive: Oxleas NHS Foundation Trust.

RESOLVED that the verbal update be noted.

16 NOTICE FROM KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST OF PROPOSAL TO CLOSE FRAILTY BEDS AT ORPINGTON HOSPITAL

The Committee considered a presentation by Peter Herring, Chief Executive, Dr Shelley Dolan, Chief Operating Officer, Chief Nurse and Executive Director: Midwifery, Matthew Trainer, Managing Director: Princess Royal University Hospital, King's College Hospital NHS Foundation Trust, Dr Angela Bhan, Managing Director: Bromley Clinical Commissioning Group and Jodie Adkin, Associate Director: Discharge Commissioning, Urgent Care and Transfer of Care Bureau, Bromley Clinical Commissioning Group and London Borough of Bromley on proposals by King's College Hospital NHS Foundation Trust to close the Elizabeth Ward at Orpington Hospital which provided frailty beds for older patients as part of a 'Step Down' facility.

The Elizabeth and Churchill Wards at Orpington Hospital opened in January 2017, making 38 inpatient beds available to older patients as part of a wider frailty model that aimed to bridge the gap between hospital and home care. Opening three months earlier than planned to help meet Winter pressures, the inpatient facility had faced a number of challenges during the first 18 months of operation including difficulties with the recruitment of permanent staff and the admission of patients with higher complexity of need than expected, and had been identified as not offering good value for money, primarily due to the high number of temporary staff. In July 2018, King's College Hospital NHS Foundation Trust notified the Local Authority that it proposed to close Elizabeth Ward as part of wider plans to refocus Bromley's integrated care model towards providing more home-based care. It was planned to deliver a number of initiatives within the new model including a Bromley Community-Based Admissions Avoidance (Virtual Ward) scheme and a Frailty Ambulatory model, and the Integrated Care Network Pro-Active Care Pathway would also be updated. The new model would be supported by robust evaluation and monitoring processes as well as the establishment of a joint integrated oversight structure that would oversee delivery of the proposed initiatives.

The Managing Director: Princess Royal University Hospital emphasised that there were no plans to close Churchill Ward, which would continue to provide 19 inpatient beds as part of the frailty model.

The Chief Operating Officer, Chief Nurse and Executive Director: Midwifery advised Members that having reviewed best practice from national bodies including the Acute Frailty Network, it was planned to move towards a care model which supported frail older people to maintain their health within their own homes or existing nursing or care home placements, which was expected to reduce 'decompensation' caused by inpatient care, where the health of individuals deteriorated away from their daily routine. The Managing Director: Bromley Clinical Commissioning Group reported that this would be supported by further development of Bromley's integrated care model, and that the Elizabeth Ward would be repurposed as an outpatient facility offering equivalent care to the previous inpatient provision in a cost effective way. The Associate Director: Discharge Commissioning, Urgent Care and Transfer of Care Bureau, Bromley Clinical Commissioning Group and London Borough of Bromley noted that the "Bromley at Home Service" initiative would offer intensive support to frail older people with an identified health need within their homes for a five day intervention period and that all key health partners would be able to make referrals to the service, including the London Ambulance Service and General Practitioners.

In considering the presentation, the Chairman voiced concern that the Local Authority had not been made aware of planned changes to the frailty model, and that key partners should continue to build stronger working relationships. The Chairman underlined the need to strengthen the role of the Health Scrutiny Sub-Committee to ensure that emerging health and social care issues were identified at an early stage, and the Managing Director: Bromley Clinical Commissioning Group confirmed that all key partners would be part of the joint integrated oversight structure to oversee delivery of proposed initiatives, including the Portfolio Holder for Adult Care and Health.

A Member was pleased to note that frail older people would be supported to maintain their health in their own homes, but was concerned that this might lead to cost implications for the Local Authority related to increased demand for social care services. The Managing Director: Bromley Clinical Commissioning Group observed that closer working between health and social care partners would improve outcomes for frail older people and that by reducing escalation of need, it was hoped to reduce the cost implications of higher level needs, such as demand for nursing or care home placements. Another Member highlighted the need to ensure that community-based services, such as those provided by Bromley Healthcare had sufficient capacity in place to meet any increased demand related to the introduction of the new model of care. The Member also noted that some social care services were means-tested which might have a cost implication for some frail older people who would otherwise have received free inpatient care. In moving to the new model, it was important for Bromley residents to understand that hospital-based care was not always the best option for frail older care and that quality care could come in many forms.

A Member underlined that the new model of care should be in place in good time to respond to Winter pressures, particularly in relation to the reduction of

inpatient beds. The Chief Operating Officer, Chief Nurse and Executive Director: Midwifery confirmed that the new initiatives would be in place by October 2018.

In general discussion, Members agreed that work be undertaken to monitor the impact of the new model of care on demand for social care services during Autumn 2018, including Delayed Transfers of Care at the Princess Royal University Hospital. Further updates on the impact of the integrated care model would be provided to future meetings of the Health Scrutiny Sub-Committee when available.

The Chairman led the Sub-Committee in thanking Peter Herring, Dr Shelley Dolan, Matthew Trainer, Dr Angela Bhan and Jodie Adkin for their excellent presentation.

RESOLVED that the presentation be noted.

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

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

18 NOTICE FROM KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST OF PROPOSAL TO CLOSE FRAILTY BEDS AT ORPINGTON HOSPITAL BACKGROUND INFORMATION

Discussions on this item took place in the Part 1 (Public) part of the meeting.

The Meeting ended at 5.17 pm

Chairman

London Borough of Bromley

PART 1 - PUBLIC

Decision Maker:	**HEALTH SCRUTINY SUB-COMMITTEE**
Date:	**17th October 2018**
Decision Type:	Non-Urgent Non-Executive Non-Key
Title:	**BROMLEY HEALTH AND WELLBEING CENTRE PROJECT: UPDATE AND PROGRESS REPORT**
Contact Officer:	Mark Cheung, Programme Director - Integrated Care Systems, NHS Bromley CCG and Project Senior Responsible Officer Tel: 020 3930 0100 E-mail: broccg.contactus@nhs.uk
Chief Officer:	Dr Angela Bhan, Chief Officer. NHS Bromley Clinical Commissioning Group
Ward:	Bromley Town

1. Reason for report

1.1 This report provides an update to the Sub-Committee on developments in the planning and approval of this key strategic project. This was previously the subject of an Update and Briefing Report to the Sub-Committee meeting on 16th June 2017.

2. RECOMMENDATION

2.1 The Sub-Committee is asked to note this report and agree that a further report should be submitted in due course.

Corporate Policy

1. Policy Status: Existing policy. N/A
2. BBB Priority: Supporting Independence. N/A

Financial

1. Cost of proposal: Estimated cost The current estimate of the capital costs of the scheme is £12.9m plus some £400k of non recurring project costs
2. Ongoing costs: Recurring cost. £9,750M (CCG commissioned clinical services) giving an estimated post development net recurrent revenue impact of £259k
3. Budget head/performance centre: NHS Bromley CCG
4. Total current budget for this head: £N/A
5. Source of funding: NHS Capital; possible S106 Funding contribution to capital costs

---

Staff

1. Number of staff (current and additional): To be confirmed.
2. If from existing staff resources, number of staff hours: N/A

Legal

1. Legal Requirement: Non-statutory - Government guidance. NHS Planning and Financial Guidance
2. Call-in: Call-in is not applicable. No Executive decision.

Customer Impact

1. Estimated number of users/beneficiaries (current and projected): 500 plus per day

---

Ward Councillor Views

1. Have Ward Councillors been asked for comments? Yes.
2. Summary of Ward Councillors comments: A briefing for local Ward Councillors was was held on the 24th November, 2017, including a brief presentation on the scheme by the CCG's Project Senior Responsible Officer, Mark Cheung. Councillors welcomed the development of a new purpose designed Health and Wellbeing Centre in a convenient town centre site with ready access to public transport. The planned inclusion of the relocated Dysart GP Surgery, which is suffering from serious overcrowding and non-compliant facilities, was particularly welcomed, given the continuing growth in local housing developments and the associated population growth.

3. COMMENTARY

3.1 Background

3.1.1 The strategic case for a third Centre, complementing the role of the ***Beckenham Beacon*** and the planned ***Orpington Health and Wellbeing Centre***, and serving some 100,000 people in and adjacent to Bromley Town centre, was one of the key proposals of the CCG-LBB jointly developed ***Bromley Out of Hospital Transformation Strategy.***

3.1.2 The Centre will play a major role in providing coordinated care for patients via integrated services and will be one of the three "hubs" underpinning the new ***Integrated Care Networks ("ICNs")***, with each ICN serving roughly a third of the London Borough of Bromley population.

3.1.3 It will also offer significant primary care services for the residents of Bromley, including a ***Primary Care Access Hub***, and the relocation of the ***Dysart Medical Practice*** from its current cramped accommodation in an adapted residential property in Ravensbourne Road, Bromley.

3.2 Project Status

3.2.1 Following approval of the CCG's bid for central capital funding support, the ***Strategic Outline Case*** was approved in December 2016 by the CCG's Clinical Executive.

3.2.2 The ***Project Initiation Document*** ("PID"), the first formal stage of the NHS Business Case development process, was approved by the NHS Executive in June 2017.

3.2.3 The ***Post-PID Full Options Appraisal*** was approved by the NHS Executive in October, 2017***.*** This stage identifies the potential sites and procurement/delivery options for the scheme and evaluates them against a set of both financial and non-financial criteria, in order to determine a shortlist and then a preferred option. A longlist of Site options had been identified in an externally sourced professional property consultancy report and these were the subject of detailed evaluation by a multi-disciplinary Evaluation Panel, which included London Borough of Bromley participation. This concluded that the ***32 Masons Hill, Bromley*** site should be the preferred option. This was confirmed in subsequent detailed financial appraisal.

3.2.4 The ***Outline Business Case*** is now in preparation and this is scheduled for completion and submission for approval by the NHS Executive in November, 2018.

3.2.5 Once approved, the ***Full Business Case*** stage will be completed, leading to financial close.

3.3 The 32 Masons Hill, Bromley Site

3.3.1 The preferred site, it is owned by Clarion Housing Group, and includes a residential development, as well as housing the ***Bertha James Day Centre***. The latter is subject to a 999 year leasehold agreement between Clarion Group and the Council and is sub leased to Age Concern Ravensbourne who operate the Day Centre via a Board of Trustees.

3.3.2 The plan is for Clarion to redevelop the whole site to include enhanced residential provision, a replacement Day Centre and the new Health and Wellbeing Centre. The planning is being undertaken in close collaboration between the stakeholders:-

- Clarion Housing Group
- London Borough of Bromley
- Bertha James Day Centre Trustees
- NHS Bromley CCG

Levitt Bernstein are the scheme architects, jointly appointed by Clarion and the CCG and are leading the Design Team.

3.3.3 The site development plans have been discussed extensively with LBB Planners via the Pre-Planning Application Guidance process, and a number of amendments and improvements incorporated in the plans as a result. However, there remains concern over the proposed replacement tower block part of the development, as this narrowly falls outside the Borough's Tall Buildings zone.

3.3.4 As a result, the scheme has been referred to the GLA Planners and a full submission has now been forwarded to them by the Design Team, with a review meeting being scheduled shortly.

3.3.5 As a result of this additional step in the overall Planning Application Process, the submission of the latter has now been rescheduled to early 2019 from its previous October, 2018 target date.

3.4 Project Governance

3.4.1 The CCG established a multi-disciplinary Project Board which will steer the Project through to the completion of the Full Business Case and Financial Close. The Board is chaired by Mark Cheung, the Project SRO, and includes representatives from LBB, as well as other stakeholders.

3.4.2 In order to ensure the effective co-ordination of the overall site redevelopment and the input of the key stakeholders, the Project Board has established a Sub-Committee for this purpose, the membership of which includes Clarion, Bertha JamesTrustees and LBB members.

3.5 Communications and Engagement

3.5.1 An over-arching Communications and Engagement Strategy was approved by the Project Board in August, 2017.

3.5.2 Following approval of the Post-PID Full Option Appraisal, the Project Board, as reported to the Health Scrutiny Committee previously, has considered whether specific public consultation is required in respect of the Health and Wellbeing scheme. It has concluded that this is not justified or necessary, as the scheme is of modest size and the only specific relocation of services relates to the Dysart Medical Practice, for which there has already been widespread support.

3.5.3 As an alternative, an Engagement Plan has been developed and agreed by the Sub-Committee. This is specifically to address the communications and engagement issues arising in the period to the submission of the Planning Application i.e. Q1, 2019.

3.5.4 In the interim, informal consultation has taken place with a number of key stakeholders, including local councillors, Bertha James Day Centre Trustees, the Dysart Medical Practice and members of the CCG's Patients Advisory Group.

4. POLICY IMPLICATIONS

4.1 The Bromley H+WBC Project was one of the key proposals of the CCG-LBB jointly developed ***Bromley Out of Hospital Transformation Strategy.*** It will operate as one of the three "Hubs" supporting the three Integrated Care Networks across the Borough.

4.2 It will bring together under one roof, in a highly accessible town centre location, a range of services including:-

- Primary Care
- Community
- Out-Patients
- Diagnostics
- Wellbeing services

4.3 It will have a particularly important role to play in helping to address the particular healthcare needs of the Bromley Town Centre population, for example the large and growing proportion of young families and children. It will also enable local healthcare provision to respond effectively to the projected population growth arising from the planned residential and commercial developments in Bromley Town Centre.

5. FINANCIAL IMPLICATIONS

5.1 The estimated capital cost of £12.9m will be funded in part via the allocation of NHS capital funds.

5.2 Overall, the development is expected to result in net additional recurring costs of £259K, for which the CCG has made provision in its forward financial planning.

5.3 The CCG will also be making provision for the non-recurring costs of the scheme's development, which include Project Management/design development and in time the Clinical services and equipment procurements.

6. LEGAL IMPLICATIONS

6.1 The proposed commercial and associated legal structure for the development has been discussed and agreed informally between the key stakeholders and will be the subject of formal proposals to the appropriate committees in due course.

6.2 The parties have already confirmed that the current LBB leasehold interest in the site will be maintained as part of the future arrangements.

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

This page is left intentionally blank

London Borough of Bromley

PART 1 - PUBLIC

Decision Maker:	**HEALTH SCRUTINY SUB-COMMITTEE**
Date:	**17th October 2018**
Decision Type:	Non-Urgent Non-Executive Non-Key
Title:	**BROMLEY MINOR EYE CONDITIONS SERVICE PILOT UPDATE**
Contact Officer:	Emily Aidoo, Clinical Commissioning Contracts Manager Tel: 0203 930 0217 E-mail: Emily.aidoo1@bromley.gov.uk
Chief Officer:	Dr Angela Bhan, Bromley Clinical Commissioning Group
Ward:	N/A

1. Reason for report

1.1 This report is to provide an update on the pilot Minor Eye Care Service (MECS) in Bromley to the Health Scrutiny Sub-Committee.

1.2 The eye care pilot started on the 1st April 2017 with the Local Optical Committee delivering the service through optical practices.

---

2. RECOMMENDATIONS

2.1 Recommendations from the Bromley MECS review (Appendix 1) for the future procurement were as follows:

i) The two year pilot will finish in March 2019. Bromley CCG is currently pulling together an options appraisal for its Clinical Executive Group and Governing body, to decide on the way forward after the pilot.

Corporate Policy

1. Policy Status: N/A
2. BBB Priority: Safer Bromley.

Financial

1. Cost of proposal: Estimated cost £325,000 over two years investment on a cost against volume contract with the provider.
2. Ongoing costs: Recurring cost. Subject to CEG decision
3. Budget head/performance centre: Commissioning- Planned Care
4. Total current budget for this head: £338,000 actual spend over two years investment on a cost against volume contract with the provider.
5. Source of funding: Efficiency funding from reduction of inappropriate referrals to secondary care and early treatment. The estimated savings total £955k over the full 2 years of the pilot.

Staff

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

Legal

1. Legal Requirement: N/A
2. Call-in: Not Applicable: No Executive decision.

Customer Impact

1. Estimated number of users/beneficiaries (current and projected): Bromley CCG estimated that up to 3000 patients will benefit from the primary eye care enhance scheme. Seen so far-

---

Ward Councillor Views

1. Have Ward Councillors been asked for comments? No.
2. Summary of Ward Councillors comments: N/A

3. COMMENTARY

3.1 In 2015, NHS Bromley CCG commissioned an eye needs assessment jointly with the Local Authority. This highlighted Bromley's ageing population and the growing burden of eye disease. Local hospital eye service (HES) capacity was already under strain. Primary care optometrists, represented by the Bexley, Bromley and Greenwich Local Optical Committee (BBGLOC) were willing to engage in new pathways utilising their skills and capacity, but there was no consensus on the best model to use. Users valued local services and had good experiences of enhanced community optometry services but wanted high quality services delivered by appropriately skilled professionals.

3.2 A Bromley eye care survey in 2017 further reinforced the need for service redesign in order to provide timely access to more primary eye care services closer to home, to try and alleviate the capacity issues in the local HES. Patients reported that they wanted to be treated faster and by the most appropriate health care professional for their needs.

3.3 This chart illustrates the responses from patients regarding the eye care service prior to the MECS introduction.

How would you rate current eye care services in Bromley in general? (364 responses) (Fig. 1)

Very good – 18.41 (67)

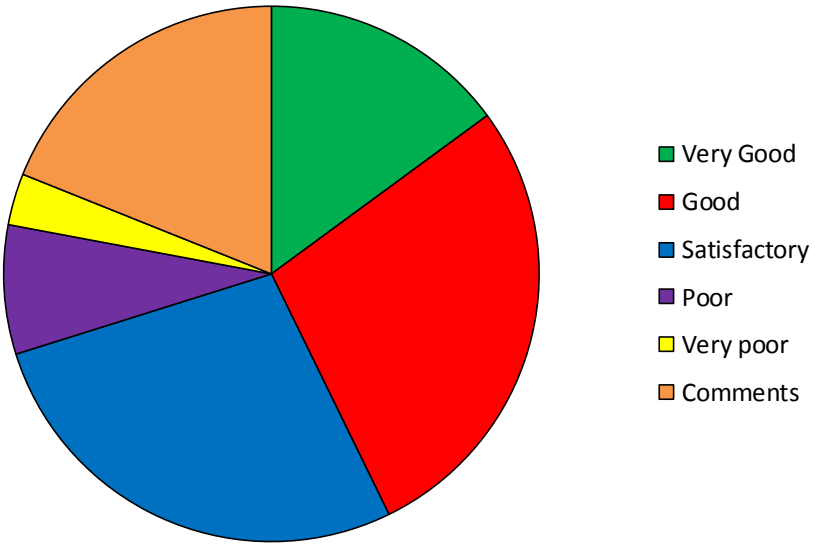
Good – 34.34% (125)

Satisfactory –33.79% (123)

Poor – 9.62% (35)

Very poor – 3.84% (14)

Comments – 23.35% (85



3.4 Comments suggest that the three most common things people complained about was extensive waiting times, lack of awareness of the types of services available and a lack of appointments:

"Waiting times can be quite long"

"More communication on what eye services are provided in the community, more posters in GP surgeries to promote this which would lead to overall a better service"

"There are little appointments as it is, especially outside working hours"

Patients alluded to the idea that the overall eye care service can be better if these issues are addressed.

3.5 A business case was brought to the Bromley Governing body in October 2016 and was approved for a two year pilot to help develop local providers and support the pathway to deliver the desired outcomes below.

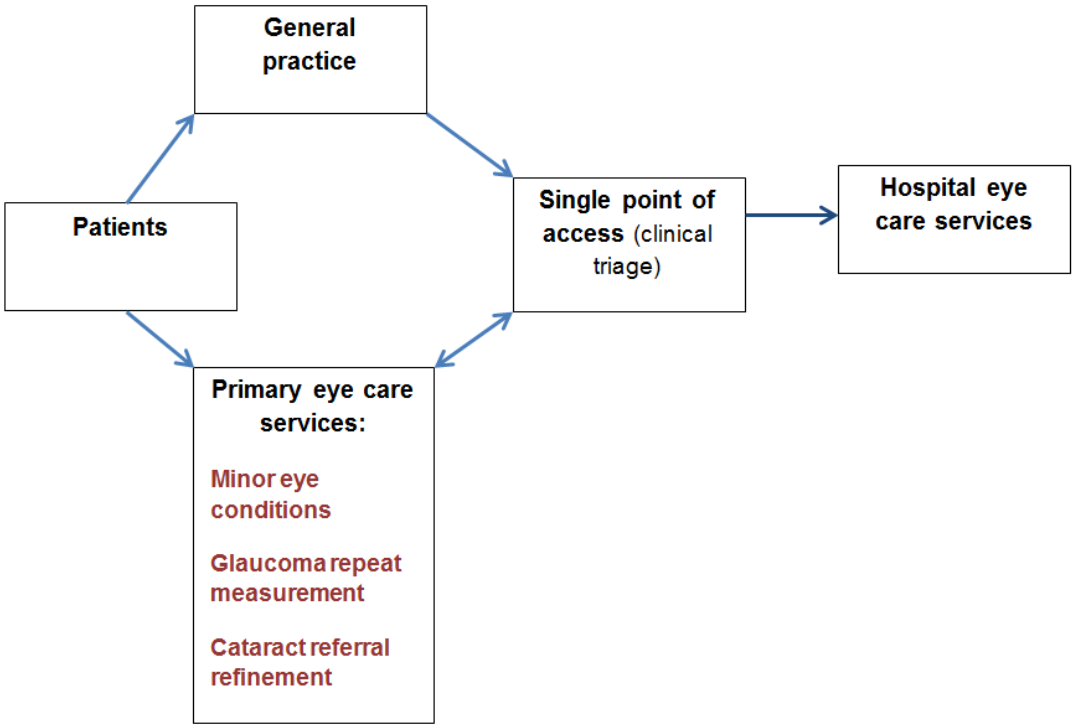
3.6 The objectives of the Bromley pilot were to allow faster access to primary eye care and reduce the number of inappropriate referrals to the HES, delivered via clinical triage and a single point of access (SPA). The NHS e-Referral (e-RS) service had introduced an "any to any" function for hospital booking from primary care providers other than GPs and a referral assessment service (RAS). NHS e-RS was launched in twelve optical practices as the first step for improving efficiencies and communication between eye care providers. The eye care pilot started on the 1st April 2017 with the Local Optical Committee delivering the service through optical practices. There are now 13 practices delivering the enhanced service across the borough with adequate provision in all of Bromley's wards, and four more are due to join imminently. This means that patients across the borough have equitability access geographically. With the extended opening times of some optical practices, this means that there is service provision over the weekend and the CCG is working towards a seven day service.

3.7 The new service is also consistent with NHSE & Bromley's commissioning strategy of:

- Developing consistent and high quality services closer to home (from the Five Year Forward View)
- Improving quality and reducing variation of care
- Developing sustainable specialist services
- Changing how we work to deliver the transformation required.

3.8 The eye care model below was commissioned with considerable input from local GP clinicians, local optometrist, and ophthalmologist and took guidance from the Clinical Council for commissioning eye care recommendations.

3.9 **GP/ Optometrist pathway model (Fig. 2)**



3.10 To ensure the effectiveness of the MECS Bromley CCG commissioned Dr David Parkins to carry out a "Service review of activity data, feedback and outcomes from the NHS Bromley CCG eye care pilot and recommendations for a future service specification"- Appendix 1. Dr Parkins incorporated feedback from Bromley Primary Care GP cluster meetings to complete this review, and presented it to the CEG in September 2018.

3.11 The actions for the remainder of the pilot were as follows:

ACTION 1: Further stakeholder engagement and communication with GP practices is required to promote the appropriate use of the MECS service.

ACTION 2: Activity appears to be to plan (Fig. 1), but there is a need to understand unwarranted variation of source of activity for two sites for conversion from sight test/ eye examination (Fig. 2 & 3). This may be a reporting issue but requires the sharing of comparative data and discussion with the provider sites to ensure correct recording of episodes. [The Standard Operating Procedure for MECS practices has been updated to highlight scenarios of presentations which would apply].

ACTION 3: Implementation of glaucoma repeat measures (filtering) within MECS practices should be followed up as part of the contract.

ACTION 4: Need to maximise the capture of unrefined referrals via the SPA triage (sourced from GP referrals, and referrals sent to GP by non-MECS accredited (or locum) optometrists for onward referral to HES (both within and outside the CCG boundary). This includes any unrefined referrals from MECS practices (e.g. where glaucoma filtering has not been undertaken). Need to ensure completeness and readability of referral correspondence (includes visual fields) on e-RS.

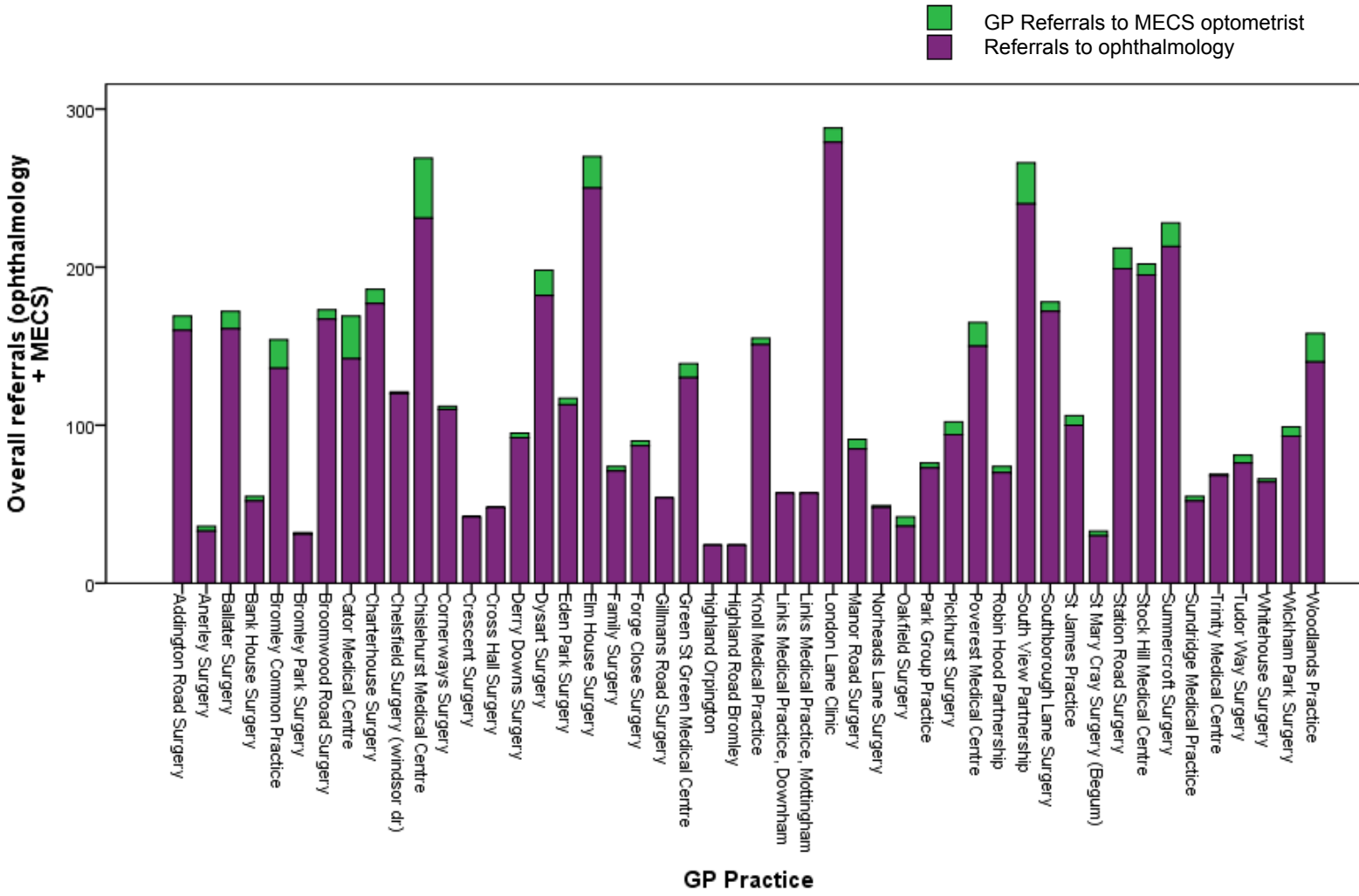
ACTION 5: Attempt to minimise waits >4 weeks to ensure any 'referrals on' to the HES can be seen within the required 18 weeks target.

ACTION 6: All referrers to MECS to receive an outcome letter from MECS optometrist. Also, GPs and optometrist referrers to receive an outcome letter from the MECS optometrist for any patient seen as a result of SPA triage.

3.12 **MECS Service Activity data 2018/19 (Fig. 3)**

Month	SPA	Referred to:		Total px episodes
		Secondary Care	BMECS	
Sept	221	153	58	124
Oct	301	240	61	196
Nov	343	225	117	248
Dec	236	179	57	200
Jan	293	230	63	296
Feb	235	181	54	293
Mar	240	189	51	370
April	285	224	61	315
May	221	187	34	363
June	246	190	56	337
July	246	190	56	342
Aug	245	172	73	315

3.13 Number of GP referrals to MECS optometrist compared with overall referrals to ophthalmology + MECS (by GP Practice) (Fig. 4)



3.14 Conclusion

3.15 The Bromley CCG eye care pilot has already made an impact on improving referral quality and reducing inappropriate referrals. More engagement and communication are necessary to promote the MECS service to GPs, to optometrists (outside the PEC service) and to patients. The CCG will continue to use contract monitoring to inform any future procurement decisions. This area of service redesign is still evolving. Future developments are possible and desirable. Our future contracts will be flexible with regular annual reviews to allow for the development and roll out of further eye care initiatives.

3.16 One of the main findings of the review regarding the service so far is that HES need to provide feedback and communication with primary eye care by sending the outcome letter to the referring optometrist/optical practice. This reply to the primary referrer is necessary for continuity of care (ophthalmologist to confirm patient consent at the end of the ophthalmology appointment). The CCG continues to include HES in Eye care Contract meetings, and to request feedback.

3.17 The two year pilot will finish in March 2019. The Planned Care team is in the current process of putting together an options appraisal for Bromley CCG CEG to decide on the best way forward after the pilot.

4. FINANCIAL IMPLICATIONS

4.1 The cost of the service was fully funded as the new service was cheaper. Not only is it cost neutral but it has also made the CCG a QIPP saving. The estimated savings total £955k over the full 2 years of the pilot.

5. LEGAL IMPLICATIONS

5.1 Legal advice around procurements was provided through South of England Procurement services as part of their service agreement with the CCG.

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

This page is left intentionally blank

NHS
Bromley
Clinical Commissioning Group

Service review of activity data, feedback and outcomes from the NHS Bromley CCG eye care pilot and recommendations for a future service specification

Report prepared by

Dr David Parkins

DOptom, MSc, FCOptom, FEAOO

July 2018

Contents

1 Background (CCG sources)

In 2015, NHS Bromley CCG commissioned an eye needs assessment jointly with the Local Authority. This highlighted Bromley's ageing population and the growing burden of eye disease. Local hospital eye service (HES) capacity was already under strain. Primary care optometrists, represented by the Bexley, Bromley and Greenwich Local Optical Committee (BBGLOC) were willing to engage in new pathways utilising their skills and capacity, but there was no consensus on the best model to use. Users valued local services and had good experiences of enhanced community optometry services but wanted high quality services delivered by appropriately skilled professionals.

A Bromley eye care survey in 2017 further reinforced the need for service redesign in order to provide timely access to more primary eye care services closer to home, to try and alleviate the capacity issues in the local HES. Patients reported that they wanted to be treated faster and by the most appropriate health care professional for their needs.

Bromley GPs confirmed the findings of the patient survey in that Bromley's ophthalmology pathways could not cope, resulting in long waiting times from referral to diagnosis and treatment. A new model of care was required to meet the present and future demands of Bromley's population; with greater access to a range of eye care services. The key was to develop services which focussed on 'right patient, right place, right time, right clinician and the right tariff'. This would be achieved through streamlining and risk-stratifying the eye care pathways and maximising the appropriate use of providers at each part of the pathway.

Commissioners in South East London (SEL) CCGs were now having conversations about the need to tackle the increasing eye care demand from primary care referrals at scale. Previously, there had been historic issues around the support and harmonisation of Primary Care Trust Local Enhanced Services (LES). The situation started in SEL when Lambeth and Lewisham CCGs worked with each other under one specification for minor eye condition services (MECS).

It was recognised that individual service developments needed to align across SEL using the following underlying drivers:

- Enabling and ensuring clinical quality, effectiveness and safety;
- Promoting and supporting prevention and self-care where possible;
- Achieving of national and local performance targets;
- Working within available resources and financial obligations including the delivery of Quality, Innovation, Productivity & Prevention (QIPP) plans, and
- Progressive development of integrated care within the NHS, social care and third sector partners.

In 2016, Bromley CCG approved a business case to commission an integrated primary and secondary eye care model, but after a robust market engagement exercise, it was clear that a pilot project would better in order to test the system. The CCG followed recommendations to waiver procurement and to pilot a model for two years from April 2017 under a primary eye care contracting framework. Learning from such a pilot would inform a more robust contract specification and sharing that learning would enable transformation of SEL eye care pathways at

scale. Since April 2018. all six SEL CCGs have been working towards aligning their primary eye care specifications.

The objectives of the Bromley pilot were to allow faster access to primary eye care and reduce the number of inappropriate referrals to the HES, delivered via clinical triage and a single point of access (SPA). The NHS e-Referral (e-RS) service had introduced an "any to any" function for hospital booking from primary care providers other than GPs and a referral assessment service (RAS). NHS e-RS was launched in twelve optical practices as the first step for improving efficiencies and communication between eye care providers. Bromley CCG was an early adopter for the use of e-RS by optical practices and therefore, its implementation has been developmental and has already provided significant learning nationally. The pilot project milestones also included the initiation of a community clinic pilot with Kings College for the monitoring of stable patients with chronic eye disease. To date, this has not commenced. However, for this to be successful, there should first be:

i) Agreed inclusion criteria for any community pilot;
ii) Prior identification of suitable patients for discharge to community;
iii) An IT solution for communications, and transfer and recording of information;
iv) A fast track referral route back to HES when required;
v) Governance and failsafe arrangements, all supported by
vi) System agreement between SEL stakeholders on a consistent set of eye health and sight loss pathways (based on risk-stratification and workforce development in terms of accreditation/ qualification requirements along the pathways. e.g. as set out in NICE Glaucoma CG81[1]).

2 England context

The challenges affecting the wider NHS and care system are all applicable to eye health and sight loss; increasing need and demand for services from the demographic changes in the population and rising prevalence of chronic disease; the introduction of interventions for previously untreatable conditions; pressures on capacity, and the competing priorities for limited resources. NHS eye health services are characteristically high-volume activities.

Increasing demand and high volume

Primary care - General Ophthalmic Services (GOS) [2]

- NHS Sight Tests - 13 million NHS sight tests performed in 2016 -17, representing a 24% increase over 10 years.

Secondary care - Hospital Eye Services (HES) [3,4]

- Outpatients: 8.5 million attendances (8% of all outpatient attendances) in 2016 -17, representing a 40% increase over 10 years.

[NB. In 2006, the Scottish GOS was refocussed to contract **all** optometrists to provide follow-up appointments for repeat measures and minor eye conditions, and this was associated with the removal of direct walk-ins to ophthalmology emergency care, as a result there has only been a 13 per cent increase in ophthalmology outpatient attendances compared with a 34% increase in England for the same period].

- Admissions:
    - over 715,000 admissions (4.5% of all admissions) in 2014 -15, representing over 40% increase over 10 years.
    - Of these 54% are cataract operations (over 382,000) which have seen a 34% increase in activity over 10 years.

Along with increasing demand, costs are escalating but despite the importance of managing these issues, there has been a lack of a whole system approach for re-aligning provision and integrating the wide range of eye health service pathways which cover school and diabetic eye screening, GOS (NHS sight tests), primary eye care, community ophthalmology, hospital eye service, social care (low vision and rehabilitation), and services provided by the charity and voluntary sectors.

Service pressures

Lack of HES capacity is leading to longer waits for new appointments, but more importantly, patient safety issues for high-risk patients resulting from delays in their follow-up appointments, hospital-initiated cancellations and backlogs; these pose a risk of harm to patients (progression of eye disease severity). This was first highlighted in 2009 by a National Patient Safety Agency (NSPA) alert for avoidable sight loss due to delayed glaucoma follow-ups.[5] Since then, there have been Care Quality Commission alerts on HES capacity issues and delayed follow-up[6,7], parliamentary questions[8,9,10], surveillance[11] and recently, a London Assembly health committee report highlighting the need for a strategic approach.[12]

Get It Right First Time (GIRFT), Failsafe optimisation, System and Assurance Framework for eye-health (SAFE) and the resultant impact on commissioning, planning and provision of eye health and care services.

The GIRFT ophthalmology project[13] is a national initiative designed to improve clinical quality and efficiency within the HES by reducing unwarranted variation. An England-wide report covering the assessment of 120 ophthalmology departments during 2017/18 is due to be published during the latter half of 2018. The National Elective Care Transformation Programme high impact intervention (HII) and failsafe prioritisation specification was launched in Q1 2018/19; with guidance and supporting materials developed with key national stakeholders.[14]

The HII specification includes three key actions to be undertaken by local Hospital Eye Services and CCGs/STP leaders:

- **Action 1** - Hospital Eye Services should develop failsafe prioritisation processes and policies to manage risk of harm to ophthalmology patients.
- **Action 2** - Hospital Eye Services should undertake a clinical risk and prioritisation audit of existing ophthalmology patients.
- **Action 3** - Each CCG/STP leaders should undertake an eye health capacity review to understand demand for eye services and to ensure that capacity matches demand with appropriate use of resources and risk stratification.

The failsafe specification Action 3 highlights the System and Assurance Framework for Eye-health (SAFE)[15] published by the Clinical Council for Eye Health Commissioning (CCEHC) as a basis for transformational change. This currently covers the main adult chronic (glaucoma and age-related macular degeneration (AMD)) and high-volume conditions (Cataract). SAFE provides the core constructs and technical tools to support the planning and provision of service systems that

take into account the full range and complexity of care pathways that (increasingly) involve multiple providers and settings to deliver services. Its implementation provides consistency in the approaches taken to improve access and availability of services, whilst managing rising need and demand.

The SAFE toolkit includes:

- SAFE Implementation of recent eye-related NICE Guidelines
- SAFE Quality Indicators for Commissioning
- Updated Vision UK Portfolio of Indicators for Eye-health and Care[16]
- CCEHC frameworks – Primary Eye Care, Community Ophthalmology and Low Vision, Habilitation and Rehabilitation. Full details can be found at: http://ccehc.org.uk

Action 3 requires CCG/STP leaders to determine the most appropriate local eye care model for delivery across primary care, community and secondary ophthalmology services, optimising skills and capacity within the system. This is necessary in order for ophthalmology pathways and referral processes to be standardised and understood locally, with patients directed to the right person, in the right place, first time. To do this effectively, there needs to be a systems approach to the commissioning and provision of integrated pathways, setting out clear responsibilities and establishing processes for governance and reporting on service implementation, quality (e.g.; serious incidents, appointment delays, patient experience) and outcomes data. SAFE recommends that in the absence of an identifiable STP structure for this, and whilst the wider system is evolving, an Eye-health Quality Board (EQB) or review group should be established linking to STP quality assurance processes. This could build on and receive input from existing local structures at CCG level for this purpose.

The SAFE cataract (Figure 1) and glaucoma (Figure 2) service systems are presented here schematically to reflect the key nodes required within each service, and the factors determining the type of care and setting in which it would be provided; by risk stratification of a patient's condition; and practitioner competencies.

CLINICAL COUNCIL
FOR EYE HEALTH COMMISSIONING

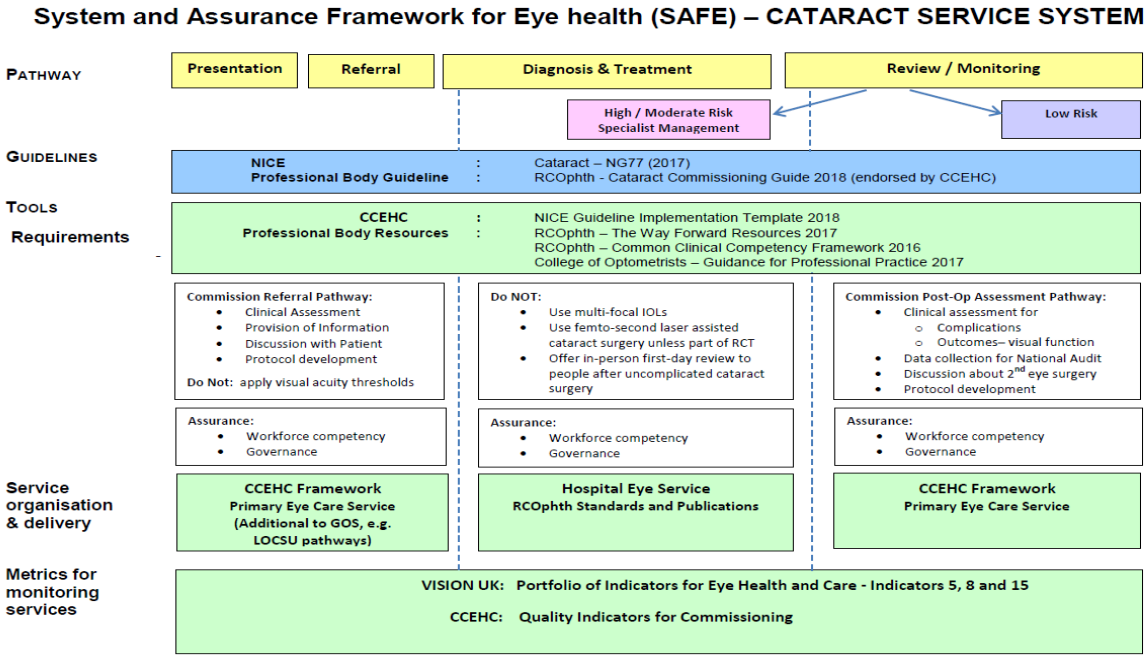


Figure 1 - SAFE Cataract system

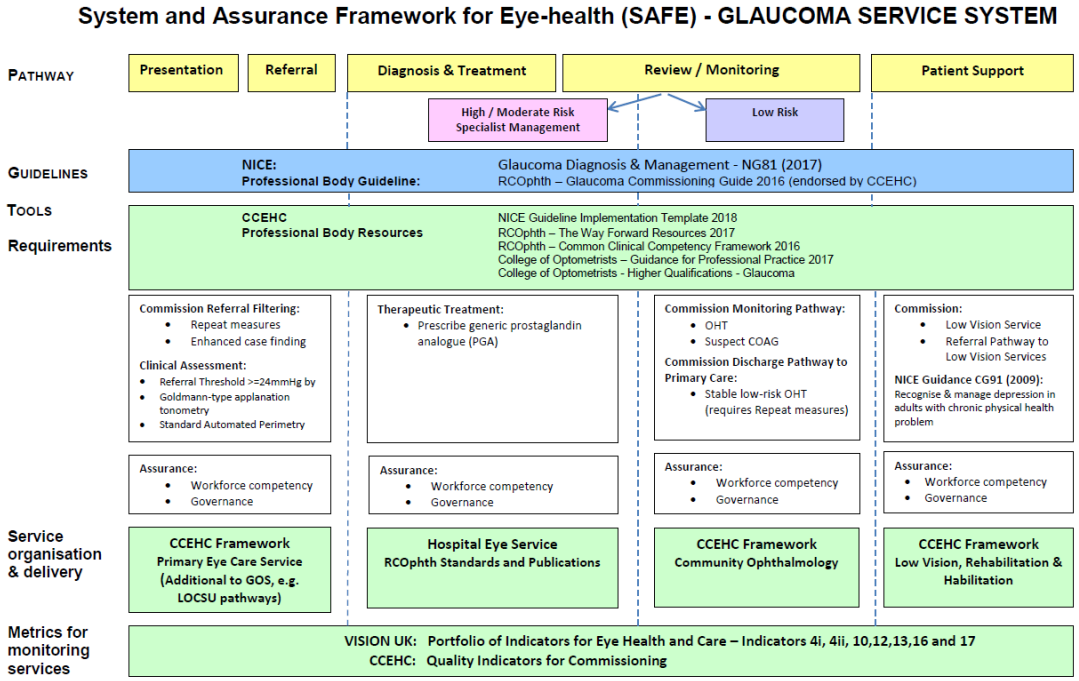


Figure 2 - SAFE Glaucoma system

3 Primary Eye Care Framework

The CCEHC Primary Eye Care (PEC) Framework[17] is a key component of SAFE and was used as the basis for the Bromley CCG pilot. The PEC framework is necessary due to the fragmentation of commissioning for first contact eye care. The NHS sight test provided under the General Ophthalmic Services (GOS) is a national delivery service contracted by NHS England. The GOS only funds a single NHS sight test appointment with a minimum recall interval, and it is the responsibility of CCGs to fund schemes to support the refinement of referrals via review and supplementary appointments. Implementation of a PEC framework additional to the NHS sight test supports better clinical decision-making and improves the quality of referral decisions. Research evidence suggests that optometrists involved in these services are three times less likely to make false-positive referrals.[18] Notably, schemes in SEL have provided national peer-reviewed evidence for repeat measures[17] and minor eye conditions.[19, 20, 21]

PEC services additional to NHS sight test include:

- Glaucoma repeat measures: repeating intraocular pressures (IOP) by Goldmann-type tonometry and repeating suspect visual field tests before referring suspect ocular hypertension / glaucoma referrals (NICE Glaucoma Guidance [CG81][1,22] and NICE Glaucoma Quality Standard 2.[23]
- Performing pre-cataract assessments, reducing unnecessary referrals:
  1. *Does the cataract affect the individual's sight and quality of life?*
  2. *Does the patient understand the risks and benefits and wishes to have surgery?*
- Managing minor eye conditions (MECS), improving links with GPs and HES.[19, 20, 21].

PEC services may also include:

- Assessments to support people with learning disabilities.[24]
- Post-cataract surgery follow-up care.[25]

In 2015, a Monitor productivity report[25] highlighted the use of primary care optometrists in delivering post-operative cataract follow-up care after uncomplicated surgery. Importantly, this facilitates the collection of essential post-operative refraction outcome data for the national ophthalmology database.[26] In addition to paper feedback options, there are now electronic data solutions available which allow optometrists to feed data directly into a hospital electronic patient record (Medisoft). Post-cataract surgery follow-up care should be considered as a future PEC development across SE London.

Use of the PEC framework and communication using e-RS supports greater efficiency of the clinical referral system. It also provides a common vision for an integrated care system from the service user's perspective which is described as *'my care is planned with people who work together to understand me and my carer(s), put me in control, co-ordinate and deliver services to achieve my best outcomes*'.

4 Scope of review

Both quantitative and qualitative approaches were used in assessing the effectiveness of the primary eye care service pilot; the scope of review was as follows, ensuring:

- Services are consistent and high quality as well as closer to home.
- Success criteria of patients being seen at the right time, place and right clinician (as per the case for change in the business case).
- Improvement in quality and reduction in variation of care.
- Development of sustainable specialist services local to patients, through a primary care/community-based service in high street optical practices.
- Improvement in access to primary eye care as specified in the service specification.
- Adherence to national waiting times for secondary care referral to treatment targets.
- Changes for how PECS is delivered to achieve the transformation required in accordance to national guidance.
- Improvement in communications between primary and secondary eye care.
- Effectiveness of e-Referral processes (GP, optometrist, triage), choice options and identify learning.
- Additional benefits to patients such as saving in time for their carer, communication and ease of accessing services.
- Additional benefits to General Practice and other providers, such as better use of referral appointments, better use of skills and competencies of the workforce and improved working relationships between providers.

Quantitative analysis:

- Activity and audit data from provider (October 2017 to March 2018 inclusive).
- SUS data (provided by CCC).
- Patient satisfaction surveys, feedback and incidents/ complaints (provided by NHS Bromley CCC).
- High-level review of the cost efficient of the new model (which may require input from the CCG financial team).

Qualitative analysis:

- High-level review of contractual requirements and benefits of using the Clinical Council for Eye Health Commissioning PEC framework as well as recommendation for future contracting methodology.
- Opportunities for community ophthalmology-type services and implications for workforce development.
- Benefits of the model through stakeholder feedback which will consist of interviews with 3 MECS practitioners and review outcomes.
- Interviews with 3 triagers and review protocols.
- Interviews with General Practice staff/clinicians (attendance at GP and cluster events).

Summary of review and recommendations:

- Consider revisions in the pilot service specification.
- Contribute to cluster meetings (4 cluster meetings total) to feedback about the review and seek GP comments on the draft report findings.
- Final report and presentation on the Bromley eye care pilot to the Clinical Executive Group, Governing Body and CCG membership groups.

Limitations of the review:

- Review after 1 year of a 2-year pilot.
- Only 6 months data.
- Service roll out still evolving.

5 Documentation review

The following Bromley Minor Eye Conditions Scheme (MECS) documents were reviewed and proposed amendments are noted below:

a) BMECS pathway diagram has been updated (Appendix B)

b) BMECS Standard Operating Procedure for practices (Appendix C).

- Clarity on typical presenting signs and symptoms for MECS and self-referrals.
- MECS appointments to incorporate glaucoma applanation tonometry (repeat measures) on first occasion as required and cataract refinement when indicated, not as an additional claim to MECS.
- Requirement for cataract assessments and repeat measures to be managed internally by optical practice as per contract especially where inappropriate or unrefined referrals are being made from non-accredited practitioners within the same optical practice.

c) Invite letter (Appendix D).

- Use of term MECS in letter. For future consideration: this links to g) and recommendation 1. This letter relates to MECS practitioners who are performing a range of refinement roles after the intervention of triage. Patients will have already been examined by another optometrist. As more services are added, the

offer to patients will extend beyond the scope of a traditional minor conditions service.

d) Booking a MECS appointment and practice sites opening times (Appendix E).

- Modify advice on drops - *Please note that as part of your examination, eye drops may be used to enable examination of the eyes. If drops are used, they will temporarily affect the ability to focus properly so you will not be able to drive for approximately 4 hours after your eye examination or until your vision has recovered. Your eyes may also, temporarily, become more sensitive to light so you may wish to wear sunglasses to relieve this. [This aligns with diabetic eye screening and HES advice to patients].*

e) NHS e-RS ophthalmology booking guidance (Appendix F).

- Clarity on expected wait times for an urgent (6 weeks) and routine (13 weeks) e-RS referrals.
- More detail on 2 weeks suspect wet AMD referral pathway and emergency referrals outside e-RS.

f) PEC triage guidance (Appendix G).

- Additional guidance for cataract, glaucoma, AMD, and floaters and flashes.

g) BMECS patient not booked (Appendix H).

- Consider shortening timescales to contact patient if MECS appointment if not made.

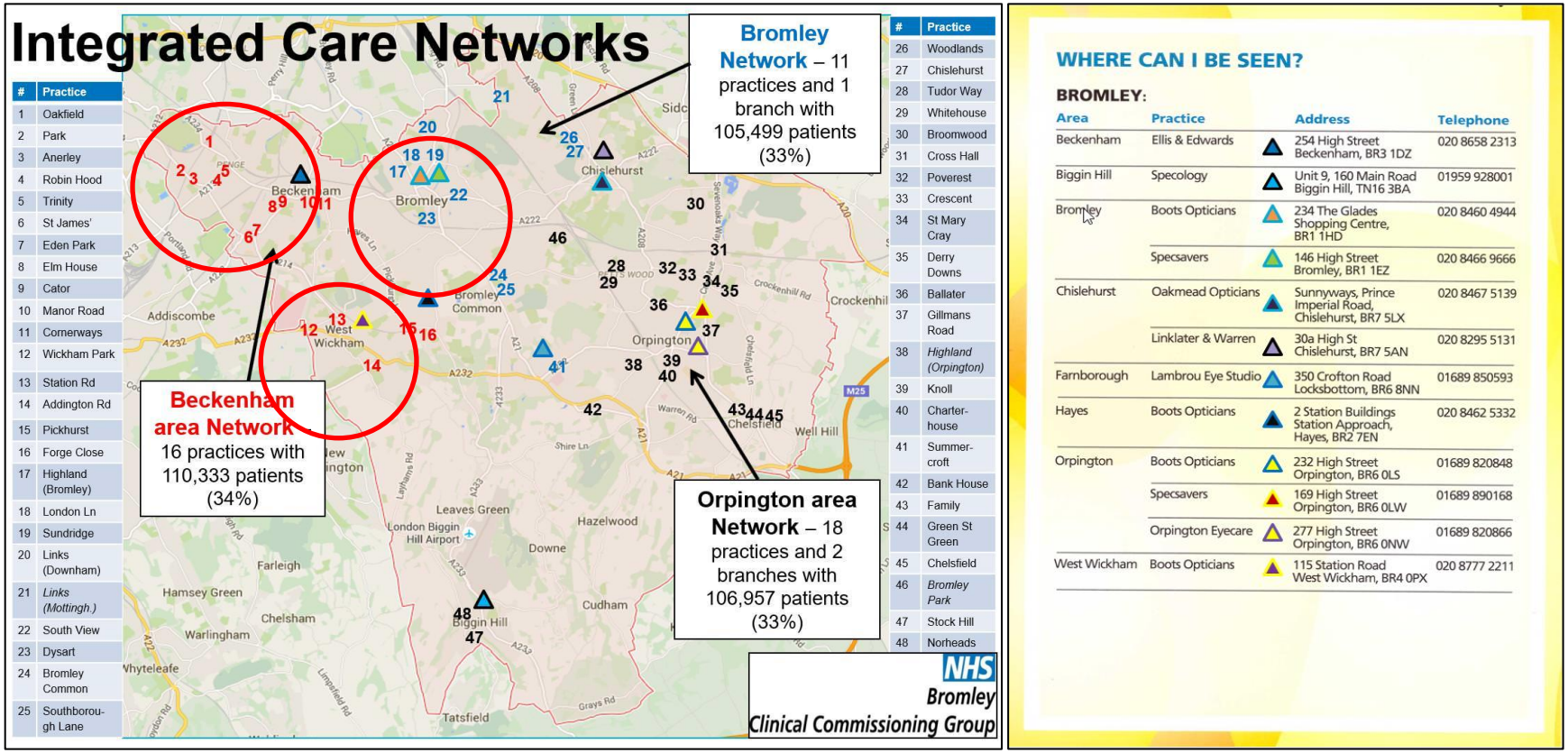
h) BECS – Service specification (Appendix I in separate file).

- Optometrists are contracted to provide a range of services which include MECS, cataract referral refinement and glaucoma repeat measures, and also use of a SPA triage via e-RS to identify those referrals suitable for further referral refinement. Across South East London, service developments have moved beyond the nationally agreed usage of the term MECS and there should be SEL agreement around a consistent set of pathways and terminology, and for the next steps in their development.
- Track changes and comments throughout document.

RECOMMENDATION 1: Clarity over terminology: consider using 'Bromley Eye Care Services' in a new procurement as the title of the **overall contract specification**. MECS would still be outward facing for GPs and the main entry point for patients. Future contracts need to cover a wider range of services, as there are opportunities for further services to be added as the workforce develops e.g. cataract post-operative care, OCT for refinement of suspect retinal conditions. Service models are already developing into lower levels of community ophthalmology, and there is significant scope for stable AMD and stable glaucoma monitoring; these would not be considered appropriate under a 'minor conditions' service (MECS).

Please note that RECOMMENDATIONS relate to a new procurement, and ACTIONS relate to the current pilot.

MECS sites within Bromley integrated care networks



WHERE CAN I BE SEEN?

BROMLEY:

Area	Practice	Address	Telephone
Beckenham	Ellis & Edwards	254 High Street Beckenham, BR3 1DZ	020 8658 2313
Biggin Hill	Specology	Unit 9, 160 Main Road Biggin Hill, TN16 3BA	01959 928001
Bromley	Boots Opticians	234 The Glades Shopping Centre, BR1 1HD	020 8460 4944
	Specsavers	146 High Street Bromley, BR1 1EZ	020 8466 9666
Chislehurst	Oakmead Opticians	Sunnyways, Prince Imperial Road, Chislehurst, BR7 5LX	020 8467 5139
	Linklater & Warren	30a High St Chislehurst, BR7 5AN	020 8295 5131
Farnborough	Lambrou Eye Studio	350 Crofton Road Locksbottom, BR6 8NN	01689 850593
Hayes	Boots Opticians	2 Station Buildings Station Approach, Hayes, BR2 7EN	020 8462 5332
Orpington	Boots Opticians	232 High Street Orpington, BR6 0LS	01689 820848
	Specsavers	169 High Street Orpington, BR6 0LW	01689 890168
	Orpington Eyecare	277 High Street Orpington, BR6 0NW	01689 820866
West Wickham	Boots Opticians	115 Station Road West Wickham, BR4 0PX	020 8777 2211

Figure 3 - PEC sites within the 3 Bromley CCG GP networks

RECOMMENDATION 2: The coverage map (Figure 3) suggests that additional MECS sites should be considered: one in Bromley, one in West Wickham and two in the Beckenham area, in order to provide improved access for patients, referrals from GP practices and cover for holidays. Over time, more local optical practices should be able to offer MECS and repeat measures, but optometrists managing low-risk referrals from SPA need to develop a greater level of skills and experience.

Activity by GP practice

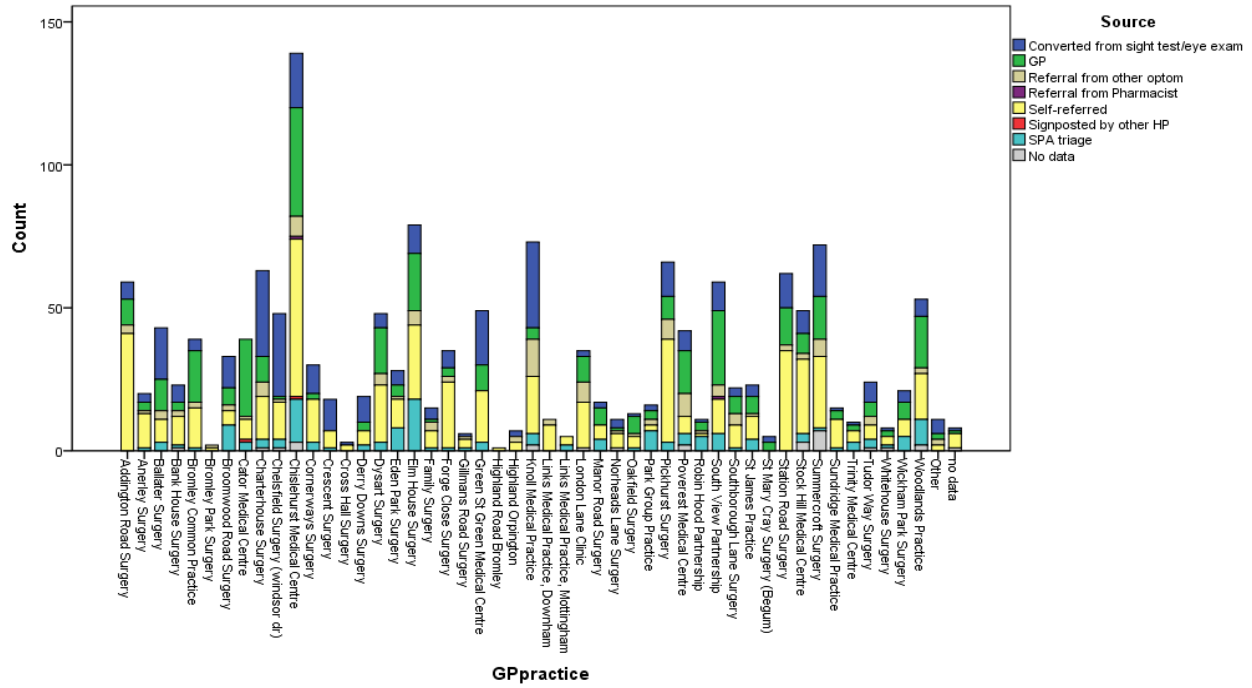


Figure 4 - Source of PEC activity (by GP practice)

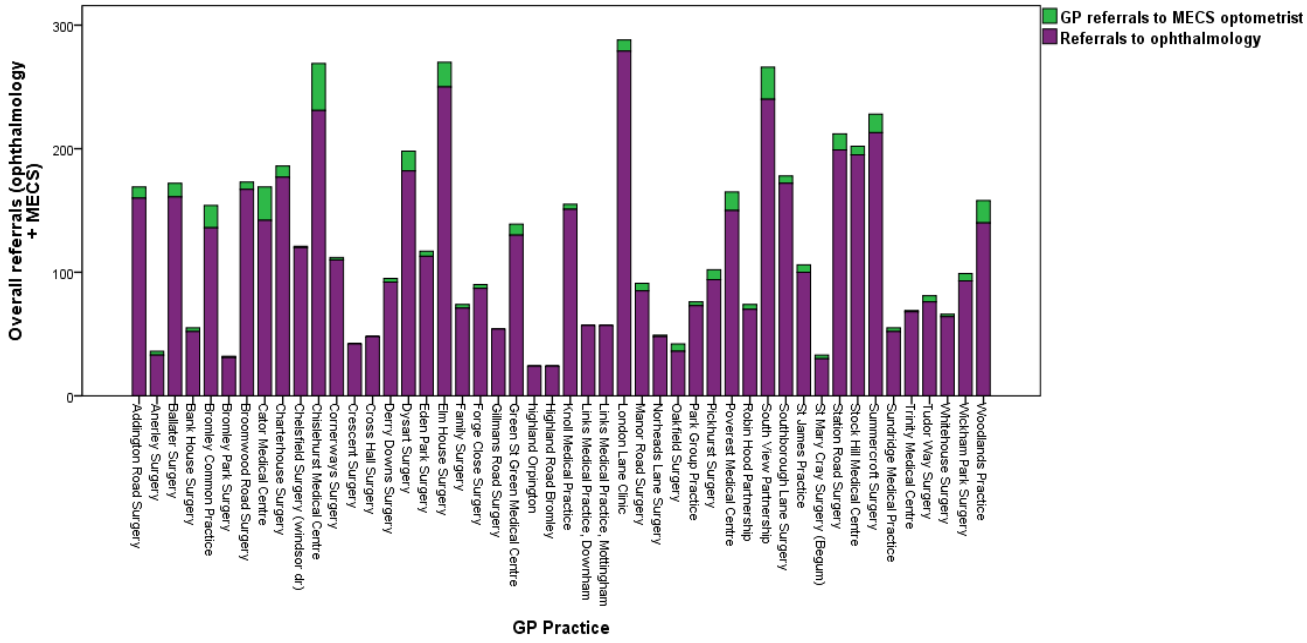


Figure 5 - Number of GP referrals to MECS optometrist compared with overall referrals to ophthalmology + MECS (by GP Practice)

Figures 4 highlights the variation in the number of referrals (green) to MECS from individual GP practices. Figure 5 suggests there is scope for greater use of MECS by GPs when this is compared to their practice ophthalmology referrals for the same period. There appears to be uncertainty by GPs around the MECS referral process and the forms to use. Old BBG PEARS forms are still in use and should be discarded. Figure 6 shows the variation in first ophthalmology referrals by GP practice (weighted per 1000 patients).

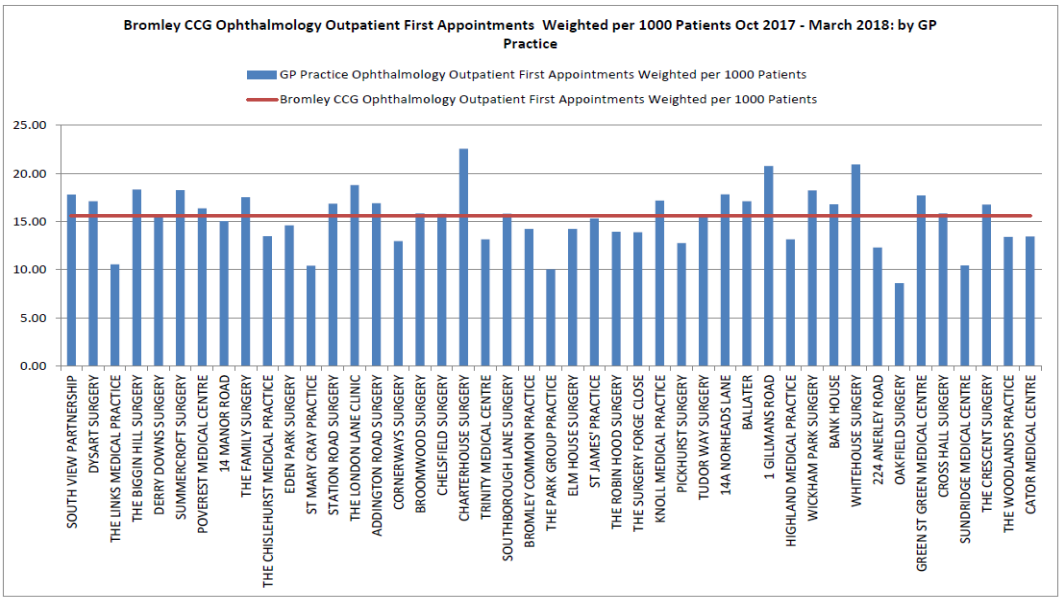


Figure 6 - 1st Ophthalmology outpatients appointments weighted per 1000 patients (by GP Practice)

ACTION 1: Further stakeholder engagement and communication with GP practices is required to promote the appropriate use of the MECS service.

Month	Full Capacity episodes (based on 2016/17)	Planned patient episodes referral (%)	Planned patient episodes (no)	Actual patient episodes	Variance
Apr-17	375	0%	0	0	0
May-17	375	0%	0	17	17
Jun-17	375	10%	38	23	-15
Jul-17	375	20%	75	75	0
Aug-17	375	30%	113	118	5
Sep-17	375	40%	150	124	-26
Oct-17	375	50%	188	196	8
Nov-17	375	60%	225	248	23
Dec-17	375	70%	263	200	-63
Jan-18	375	80%	300	296	-4
Feb-18	375	90%	338	293	-45
Mar-18	375	100%	375	370	-5

Table 1 - Patient activity

ACTION 2: Activity is to plan (Table 1, Appendix A), but there is a need to understand a degree of unwarranted variation of source of activity for two sites for 'conversion from sight test/ eye examination' (Figures 7 & 8). This is most likely a reporting issue but requires a review of comparative data and discussion with the provider sites to ensure appropriate recording of episodes. [The Standard Operating Procedure for MECS practices has been updated to highlight scenarios of presentations which would apply].

Source of activity

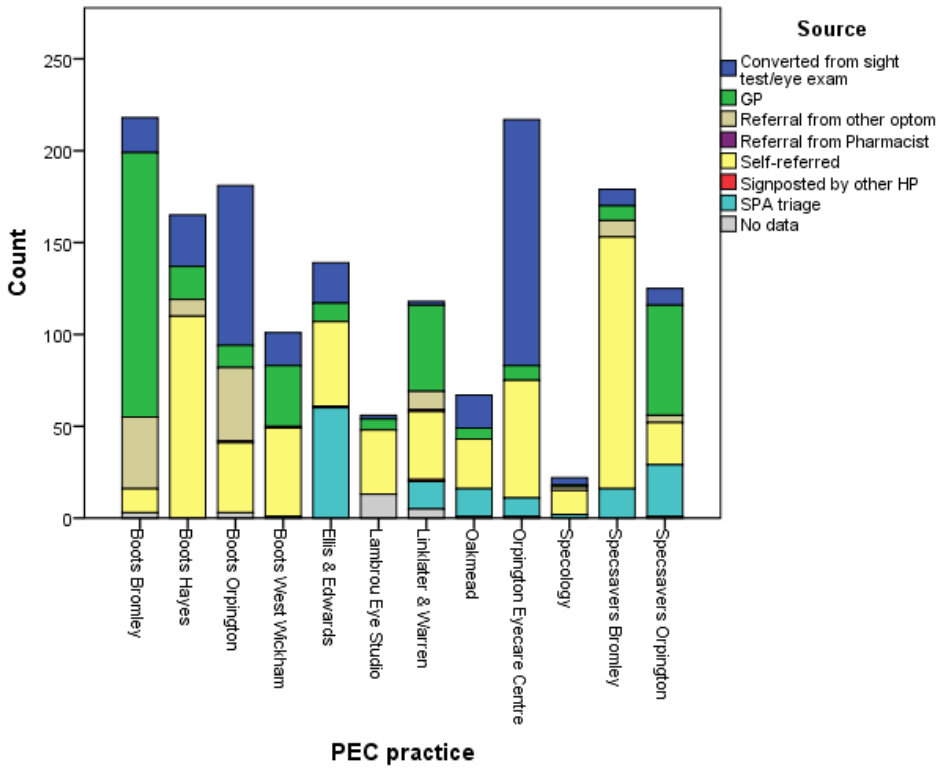


Figure 7 - Activity by MECS practices

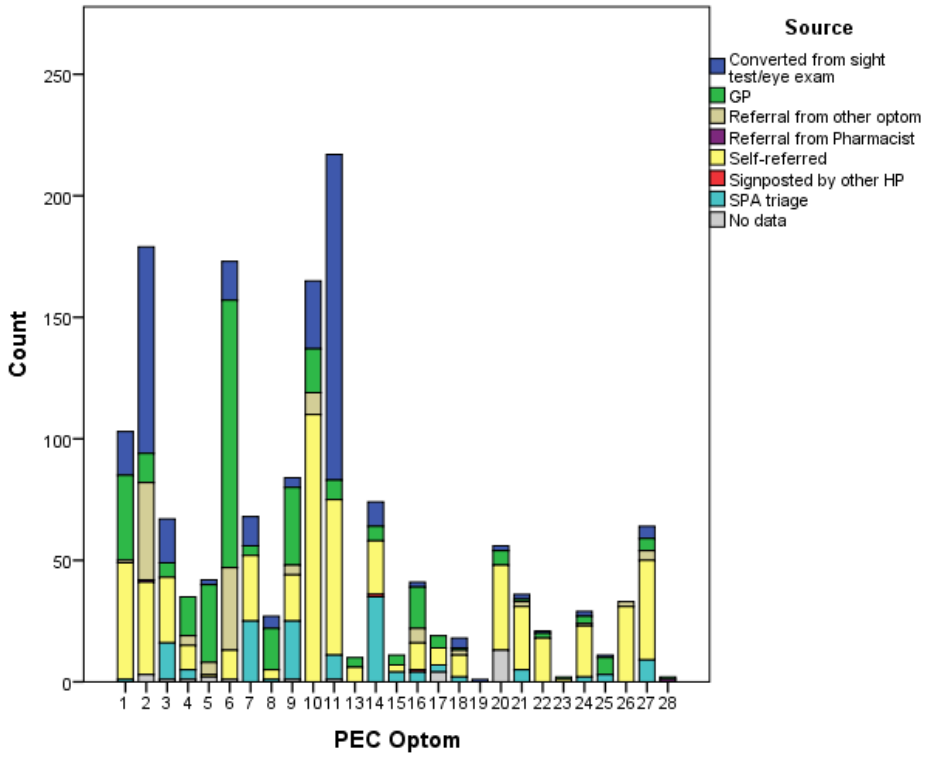


Figure 8 - Activity by MECS practitioner

Reason for activity

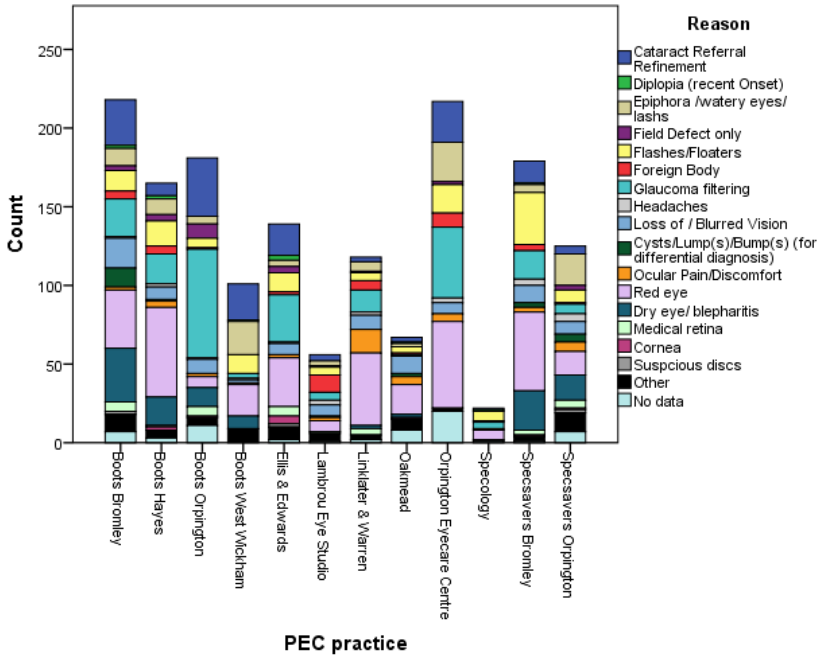


Figure 9 - Reasons for activity by MECS practice

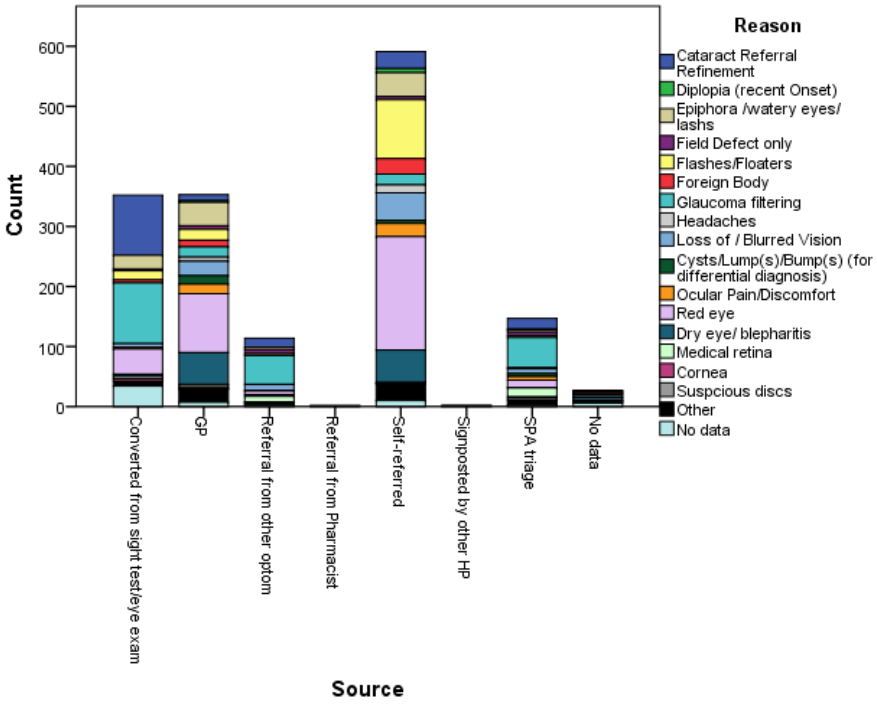


Figure 10 - Reasons for activity by source

The reason for PEC activity varies by MECS practice and by source (Figures 9 & 10). Several practices are highlighted where no or little glaucoma filtering is taking place. Glaucoma repeat measures is part of the service specification.

GPs are referring to MECS for mostly red eye and dry eye/blepharitis. The main reasons for conversion from a sight test appear to be for cataract refinement and glaucoma repeat measures. This is slightly confusing, cataract assessment and glaucoma repeat measures are more

accurately reported as ‘additions to the sight test’, as a sight test is completed and not stopped at any point. Appropriately, red eye, and floaters and flashes are the main reasons for self-referrals.

ACTION 3: Implementation of glaucoma repeat measures (filtering) within MECS practices should be followed up as part of the contract.

Outcomes for MECS/Cataract/ Repeat measures appointments

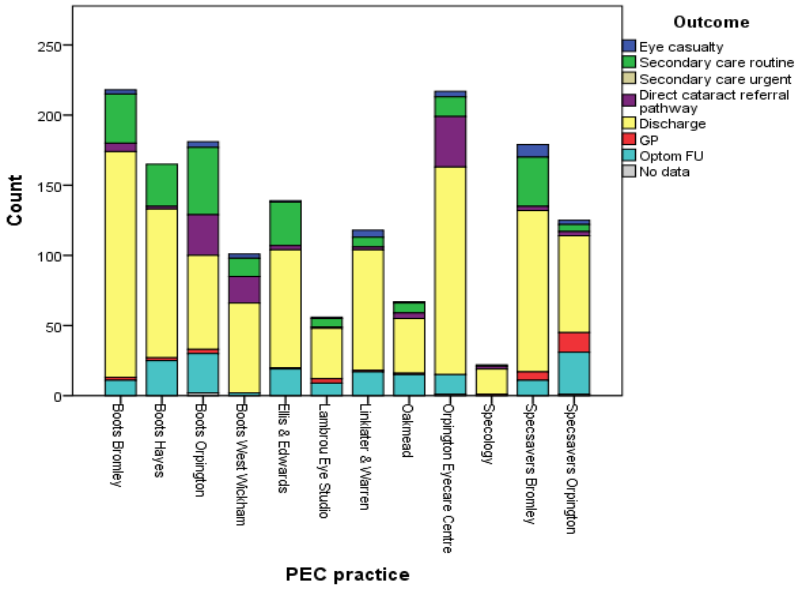


Figure11 - Outcomes by MECS practice

There is a high discharge rate across all practices, and across all activity sources (Figures 11 & 12) and modest usage of MECS follow-up appointments (light blue).

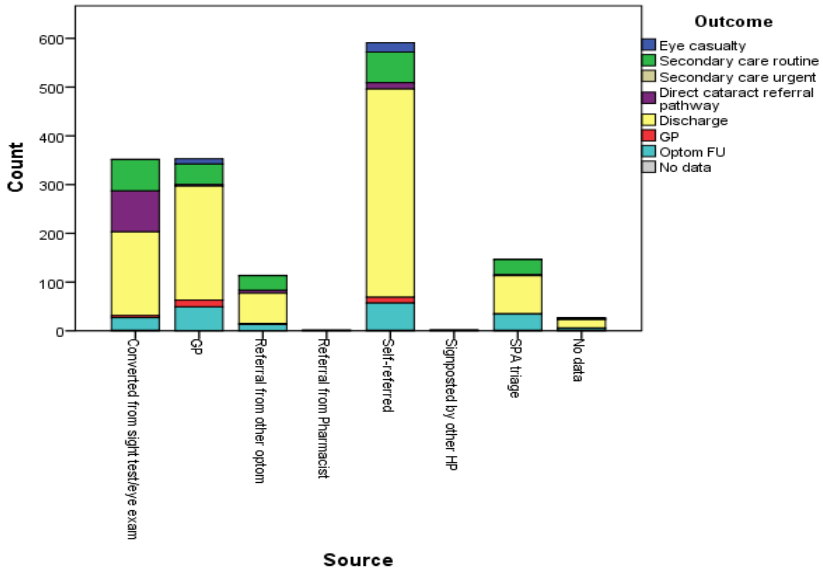


Figure 12 - Outcomes by source of referral

Glaucoma filtering is the main activity from the SPA. More glaucoma filtering activity in terms of ‘enhanced case finding’ (which involves dilation) should be possible from SPA triage during the second year of the pilot, as approximately 60% of local optical practices are currently outside the pilot and additionally 15% of referrals may be received from optical practices outside Bromley CCG boundaries. Reports of unreadable letter scans on e-RS needs to be investigated and steps taken to improve.

ACTION 4: Need to maximise the capture of unrefined referrals via the SPA triage (sourced from GP referrals, and referrals sent to GP by non-MECS accredited (or locum) optometrists for onward referral to HES (both within and outside the CCG boundary). This includes any unrefined referrals from MECS practices (e.g. where glaucoma filtering has not been undertaken). Consider plan to improve readability and completeness of referral correspondence (includes visual fields) on e-RS.

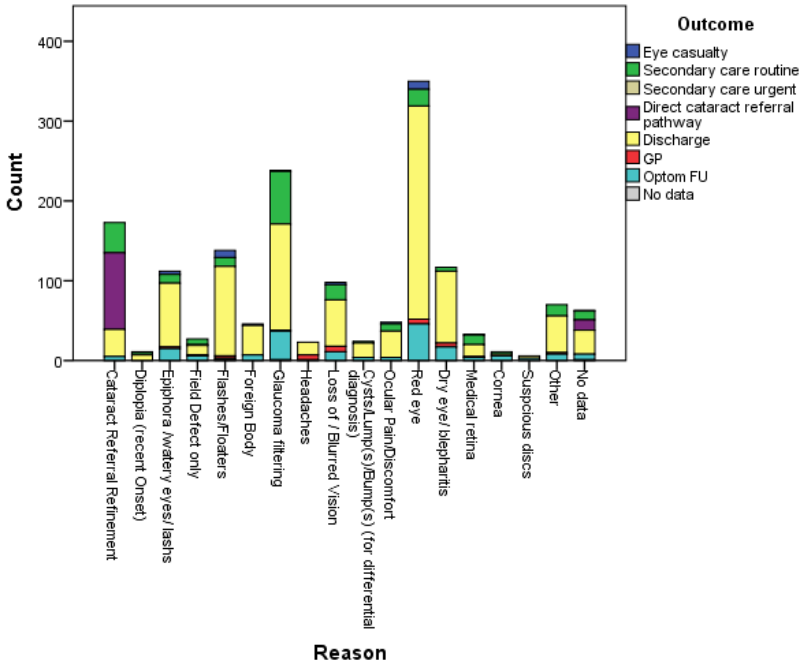


Figure 13 - Outcomes for PECS/ MECS appointment by reason

Outcomes of non-referral/ discharge occurred in 20% of cataract refinement assessment, 67% of glaucoma filtering assessments, and MECS is supporting clinical decision-making resulting in non-referral for the following presentations: red eye 92%, dry eye/ blepharitis 97%, floaters and flashes 91%, and removing foreign bodies 85% (Figure 13).

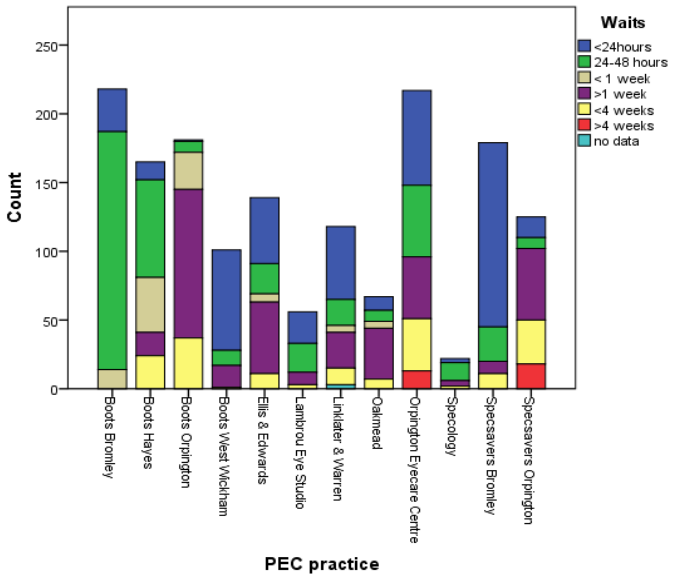


Figure 14 - Waits for appointment by PECS/MECS practice

Waits varied by optical practice; these differ based on source of referral e.g. appointments as a result of triage will take longer to arrange than GP to MECS referrals (Figure 14). A few practices had waits >4 weeks but this may be due to patient choice. Ideally, waits >4 weeks should be minimised.

ACTION 5: Attempt to minimise waits >4 weeks to ensure any 'referrals on' to the HES can be seen within the required 18-week target.

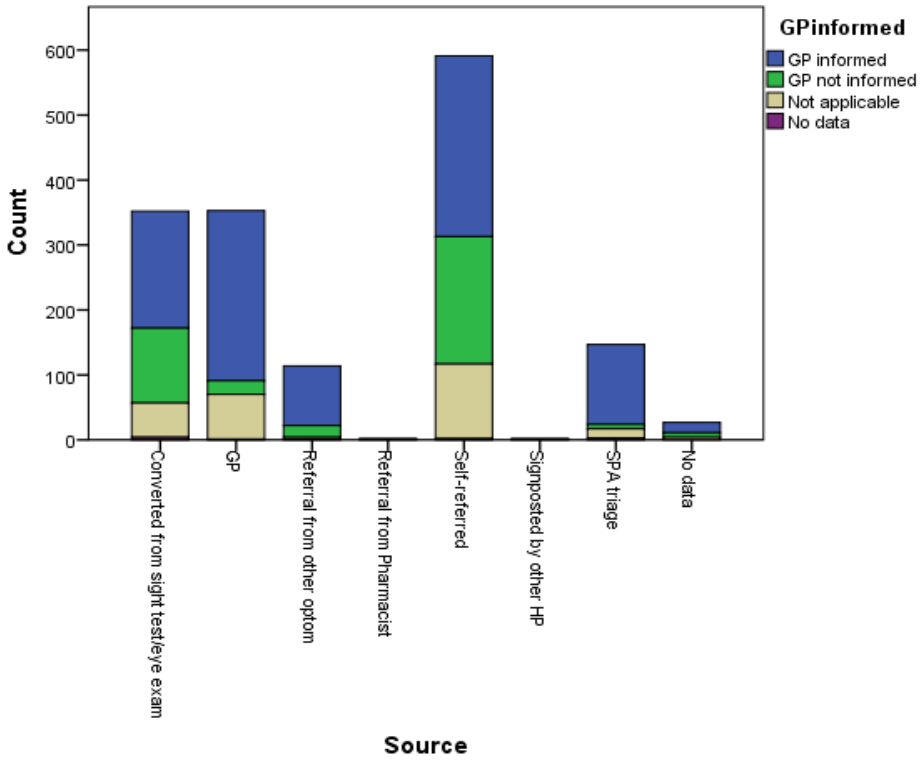


Figure 15 - GP informed of MECS appointment

A MECS outcome letter to the referring GP was reported as 'not applicable' in a number of cases (Figure 15). This may be a recording issue, or it could be that the GP receptionist had directed the patient to MECS. To be clear, all MECS episodes following GP referral require an outcome letter whether their patient has been referred by a GP or the review is as a result of triage. There needs to be similar requirement to send a copy of the MECS outcome to the referring optometrist. This is essential feedback and needs to happen to complete the optometrist referral improvement loop. This point was also made by the MECS optometrists *(see MECS optometrists feedback).* There is no requirement to inform the GP in self-referral cases and conversion from a sight test where no reason requiring referral is found.

ACTION 6: All referrers to MECS to receive an outcome letter from MECS optometrist. Also, GPs **AND** optometrist referrers to receive an outcome letter from the MECS optometrist for any patient seen as a result of SPA triage.

7 Feedback

Visits and conversations took place during April 2018 with 4 MECS optometrists, 3 SPA triagers and attendance at a Bromley GP CPD event on urgent eye referrals (23rd April 2018). There was good support for MECS from all stakeholders, and a willingness to develop and expand the service. However, rather than feedback and ideas for the future, possibly because this was a new service, much of the conversations were around clarity over what to do in certain circumstances. Undertaking a pilot therefore was the correct decision with the continuing need for wider and improved communication across all groups.

The following points and queries were identified; answers and considerations are provided in italics.

Triage

- Visual fields plots are missing from many suspect glaucoma referrals when the letter reports abnormal fields. Triage optometrists reported that some referrals on e-RS do not have the optometrist referral letter and/ or visual field plots attached, but instead there is a short summary in the GP referral letter. GPs reported that the resulting optometrist referral letter scans are often unreadable. Consequently, essential information does not reach the ophthalmologist. ***Answer:*** *Approach Local Optical Committee (LOC) to communicate a request to all local optometrists to include suspect visual field plots with their referral when they make reference to a visual defect. CCG to communicate with GPs that they forward all readable optometrist referral correspondence including visual field plots with the referral. Investigate instances of poor quality scans (links to action 4).*
- Insufficient information in the referral letter, should this stop or reject the referral?
  Answer: *If there is a general indication that the patient should be seen by the HES rather than MECS refinement, reduced referral quality should not slow the patient referral. This should be reported to the SPA office, so that feedback can be given to the referring practice/practitioner. Where there are obvious omissions, or the scan is unreadable, so that a triage decision cannot be made, then reference back to the referring practitioner is necessary.*
- What is the appropriateness of SPA triage guidance for patients who are referred on e-RS with recent floaters and flashes. Current triage guidance for those patients with onset within 4 weeks of referral date is 'refer HES URGENT', and onset over 4 weeks 'refer into MECS'. These patients may already have been dilated and examined by an optometrist, but this may not be the case if referred by the GP.
  Answer: *Management of floaters and flashes should be in line with the NICE clinical knowledge summary on management of suspected retinal detachment whatever the presentation or referral route. If no visual acuity change or field loss, and no practitioner has yet examined the patient's retinae, they should be reviewed within 24hrs for dilated SL-BIO examination by the MECS optometrist; if there are symptoms reported of changes in visual acuity or visual field loss, then the patient needs to be referred direct to emergency eye casualty/ rapid access same day (Appendix G).*
- Identification of outlier referral practices, lots of referrals for asymmetric disc cupping. Should MECS optoms be dilating for suspect OHT/glaucoma case finding?
  Answer: *Repeating measures by the initial optometrist is quite different to another practitioner seeing the patient after referral by the first practitioner. The level of assessment should be higher at 'enhanced case finding' level, which would include dilated disc assessment (assuming patient consent and assessment of angle), visual fields and*

Goldmann-type tonometry. This is in line with NICE glaucoma CG81 enhanced case finding practice.

- Unwarranted variation in referral quality from several referral outlier practices and practitioners identified by the triage. ***Answer:*** *Feedback should be made direct to the SPA so they can contact the practice and practitioner to inform future referrals.*
- Cataract referrals appear to be generally good, some optometrists questioned the need for diversion for cataract assessment as patient expectations have been set. ***Answer:*** *Cataract referral guidance and treatment thresholds should be aligned using the London choosing wisely cataract protocol (available soon). Cataract pre-assessment should be part of the referral decision-making process, it is less effective following SPA triage.*

MECS Optometrists:

- GPs like the service and patients are pleased with MECS.
- It was reported that some GP reception staff are not giving out forms or information letters to patients, just advising them to go and see MECS optometrist. *[Relates to Action 1. communication with GP reception staff is needed as some of these patients could be seen under the GOS].*
- Patients expect to be seen immediately without an appointment. *[Relates to Action 1 on communication].*
- Optometrist letter is not always attached to GP referral on e-RS.
- Some GPs do call MECS practice in advance to provide more clinical information.
- Does MECS really need to see patients who have had a chalazion present for 3 months and not resolving? Patients are attending expecting these to be removed by the MECS optometrist.
  Answer: *Consider advice for Chalazion (un-resolving) and present for over 10 weeks to be referred to HES for incision and curettage.*
- Important for feedback to referring optometrist, as well as GP.
- What constitutes a headache symptom being referred into MECS?
  Answer: *This needs to be ocular headache and when an NHS sight test cannot be provided. Therefore, such circumstances should only arise very occasionally.*
- Can we have clear guidance on eye conditions suitable for MECS? And when should a patient be booked in for an NHS sight test (GOS)?
  Answer: *Updated guidance (Appendix C).*
- Use of e-RS has been a steep learning curve. Can we have better e-RS instructions as not always easy to track down or view referral letter? ***Consideration for PECS Provider.***
- When do we use glaucoma repeat measures?
  Answer: *Repeat GAT IOPs when NCT 24-approx 29mmHg.*
- There is never any correspondence to optometrist on referral outcome from Kings College, while Maidstone Hospital do reply back to the optometrist.
  Consideration for CCG and local Ophthalmology*: HES to increase feedback to referring optometrist on referral outcome for continuity of care and improving future referral appropriateness.*
- Reports that patients are waiting 5 months for Yag laser by the HES (April for Sept 2018).
- Need for peer review of referrals within MECS practices/ adherence to practice guidelines.
- Outliers – highlighted impact of locums who refer on the day rather than internally.
- More guidance for MECS optometrists on Choice booking options.
- GPs need to include more patient history for MECS, e.g. antibiotics used and other medication.
  Consideration for CCG*.*

Booking and IT issues:

- Poor appointment slot availability PRUH and QMS.
- Referral administration, limitations of laptop with multiple optometry clinics.
- No straightforward way to generate letter on e-RS, requires keyboard with smart-card slot.
- Working with multiple systems, the laptop is not integrated with practice systems and instances of not linking with printer, time taken to complete is longer and often after patient has gone, choice is offered prior to going on system so useful to have referral templates on laptop as easier to compose referral letters, and email letter to GPs and give patients a copy.
- Laptop screen is too small.
  IT considerations for CCG and PECS provider.

GP event

- General support for MECS.
- Not sure which forms to use, or where they can be accessed on the GP systems.
- Not sure of opening times at QMS rapid access clinic *(8.30am-4.00pm daily).*
- GPs want more information. *Links to Action 1.*

GP Cluster meetings

- GPs have noticed a reduction in the number of optometrist referrals.
- It was suggested that more optometrists needed to get involved in the schemes.
- Comment by one GP, 'GPs need to continue to manage straightforward cases e.g. conjunctivitis as they do have some knowledge of common external eye conditions', but this is limited by the lack of necessary equipment for further investigation.
- Sometimes, there is poor readability of the optometrist letter when received and this was a common theme. GPs cannot read them and therefore it is pointless to attach scan to records.
- 'It would be much better if everyone was on the same electronic system'.
- Direct referral for all ophthalmology was supported by GPs, one GP said they felt like a 'secretary' in the process. ***Consideration for CCG:*** *This could be supported with hub access to the local care record via EMIS community and information sharing agreements with GP practices and HES.*
- Concern was expressed when the optometrist referral letter states urgency 2-4 weeks, e.g. in cases of blurred disc margins GPs cannot do this on e-RS, so they refer direct to rapid access clinic. ***Consideration for CCG:*** *These types of referrals have increased with a recent high-profile case. There should be discussions with Kings and agreement on a 2-week pathway on e-RS, and advice to optometrists and GPs on referral criteria with appropriateness of referral timescales.*

HES

- Agreement for alignment of whole system SEL pathways.
- Boundaries, failsafe and step-down responsibilities need to be clear.
- HES have a responsibility to see all patients referred to them, it is the responsibility for primary care to improve quality of referrals.

General observations on community ophthalmology:

- CCEHC's Community Ophthalmology framework[27] describes a greater role for a multi-disciplinary team of practitioners working above primary care in community ophthalmology and in collaboration with HES. This could be HES or community led.
- The development of community ophthalmology should be a priority area, but this will require innovation and joint working between key stakeholders and services in SEL.
- Step down to primary and community care will only occur when there is confidence on the part of the HES that patients will be appropriately managed with clinical communication flowing both ways.
- Engagement needs to continue across SEL between patients, clinicians and commissioners.

RECOMMENDATION 3: Quarterly meetings involving commissioners and providers to focus on the development of community ophthalmology service model involving primary and HES providers. Communication and closer liaison between primary eye care lead and HES lead. This could involve direct contact as required and separate one-to-one meetings to improve local issues.

RECOMMENDATION 4: Community ophthalmology model will require further development around failsafe (tracking of patients and outcomes), and workforce planning and training (e.g. informed by risk stratification of pathways) to provide assurance. The SPA could be used as a step-down route to provide such failsafe.

8 System activity analysis

It has been difficult to make a full assessment based on only six-months of data, but analyses confirm that primary eye care referral activity is being managed more appropriately. Eighteen-week support was used locally during 2017/18 and will impact on waiting time performance (Figure 16). Data shows that Bromley GP ophthalmology referrals (including optometry referrals) have been lower in 2017/18 confirming GP cluster observations (Figure 17). While ophthalmology activity data might be accurate, there are obvious errors in reporting at subspecialty and procedure level (highlighted yellow Table 2). This is a national issue, but improved quality of these data would enable commissioners and providers to have more confidence in monitoring and planning services. However, improved quality of data and procedure reporting might identify the need for more funding. ***Consideration for CCG Contract Board.***

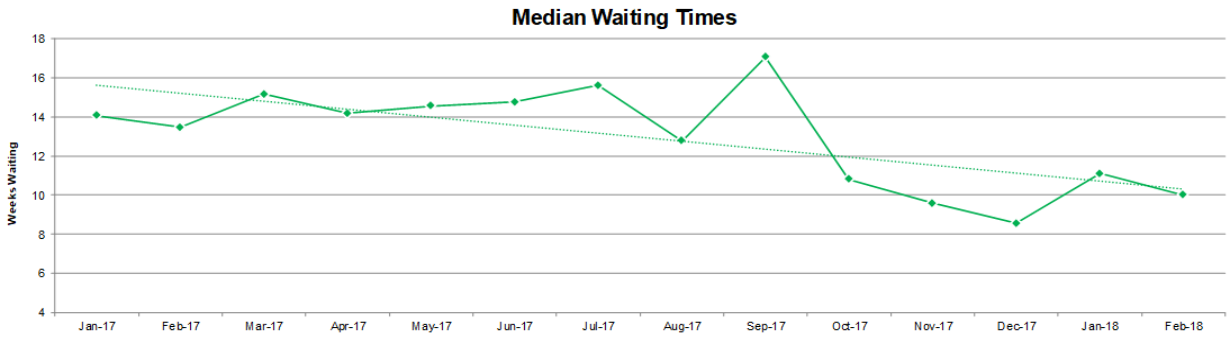
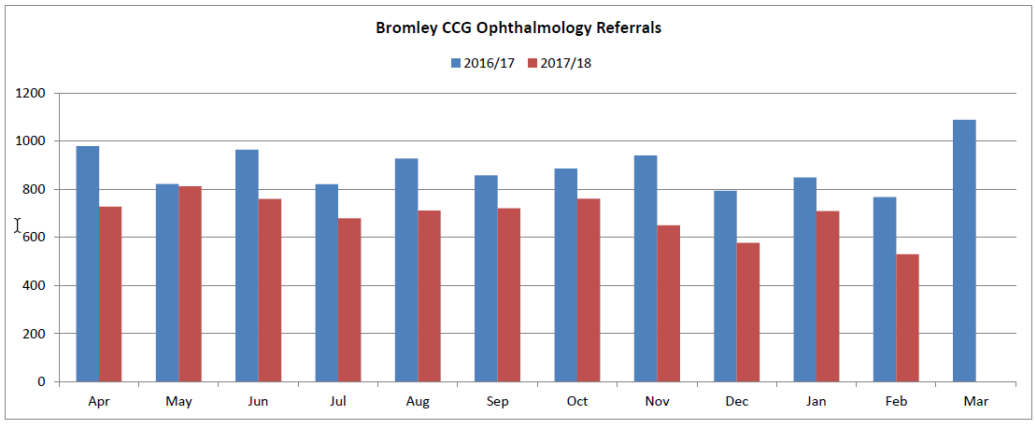


Figure 16 - Kings ophthalmology waiting times

[Kings College Hospital NHS foundation Trust NHS Bromley CCG Ophthalmology non-admitted]



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD
2016/17	979	822	965	821	928	858	886	940	794	849	768	1089	10699
2017/18	728	813	760	680	711	721	761	650	578	710	530		7642

Figure 17 – Bromley GP Ophthalmology referrals

All Bromley CCG Ophthalmology Outpatient Procedures by HRG Label			
HRG Label	**2016/2017**	**2017/2018 YTD (Feb)**	**2017/2018 FOT**
Vitreous Retinal Procedures - category 1	11059	0	0
Retinal Tomography, 19 years and over	0	8903	9712
Intermediate Vitreous Retinal Procedures, 19 years and over, with CC Score 0-1	0	1655	1805
Vitreous Retinal Procedures - category 2	965	0	0
Minor Vitreous Retinal Procedures, 19 years and over	0	816	890
Lens Capsulotomy	450	0	0
Minor, Cataract or Lens Procedures	0	388	423
Major Vitreous Retinal Procedures, 19 years and over, with CC Score 0-1	0	271	296
Oculoplastics category 1: 19 years and over	201	0	0
Glaucoma - category 1	140	0	0
Minor, Glaucoma or Iris Procedures	0	136	148
Minor Oculoplastics Procedures, 19 years and over	0	146	159
Intermediate, Glaucoma or Iris Procedures, with CC Score 0	0	88	96
Digital Retinal Photography, 19 years and over	0	75	82
Minor, Orbit or Lacrimal Procedures, 19 years and over	0	73	80
Intermediate Oculoplastics Procedures, 19 years and over, with CC Score 0-1	0	64	70
Orbits / lacrimal category 1: 19 years and over	52	0	0
Minor Ocular Motility Procedures, 19 years and over	0	41	45
Cornea / Sclera - category 1	32	0	0
Minor Skin Procedures, 13 years and over	0	22	24
Intermediate Skin Procedures category 2 without CC	21	0	0
Major Oculoplastics Procedures, 19 years + with CC Score 0-1	0	16	17
Intermediate, Orbit or Lacrimal Procedures, 19 years and over, with CC Score 0	0	7	8
Minor, Cornea or Sclera Procedures	0	3	3
Oculoplastics category 1: 18 years and under	3	0	0
Electrocardiogram Monitoring or Stress Testing	0	2	2
Minimal Nose Procedures, 19 years and over	0	4	4
Major, Glaucoma or Iris Procedures, with CC Score 0-1	0	2	2
Minor Vitreous Retinal Procedures, between 4 and 18 years	0	1	1
Intermediate Skin Procedures, 13 years and over	0	1	1
Grand Total	**12923**	**12714**	**13870**

Table 2 - Ophthalmology outpatient procedures

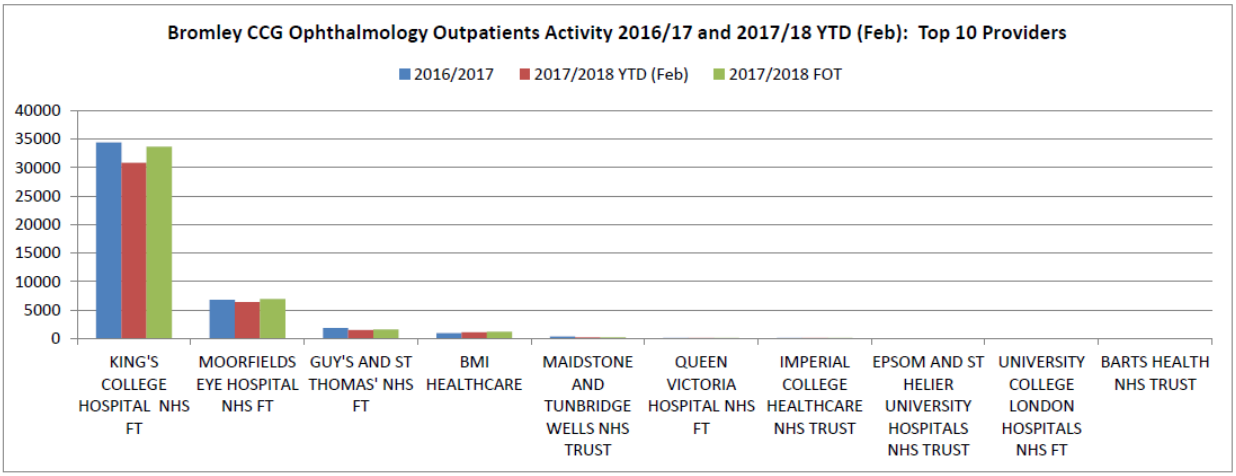


Figure 18 - Ophthalmology outpatients activity

Ophthalmology Outpatients Activity by Top 10 Providers	2016/2017	2017/2018 YTD (Feb)	2017/2018 FOT
KING'S COLLEGE HOSPITAL NHS FT	34420	30862	33668
MOORFIELDS EYE HOSPITAL NHS FT	6829	6399	6981
GUY'S AND ST THOMAS' NHS FT	1887	1486	1621
BMI HEALTHCARE	954	1103	1203
MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	350	227	248
QUEEN VICTORIA HOSPITAL NHS FT	132	116	127
IMPERIAL COLLEGE HEALTHCARE NHS TRUST	112	108	118
EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST	66	56	61
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FT	38	45	49
BARTS HEALTH NHS TRUST	42	44	48

Table 3 - Ophthalmology outpatients activity by provider

Ophthalmology outpatient appointment activity (2016/17 and 2017/18 is broadly the same across all providers, with a small rise for BMI healthcare Figures 18,19,20, Table 4). Ophthalmology activity includes both new and follow-up appointments.

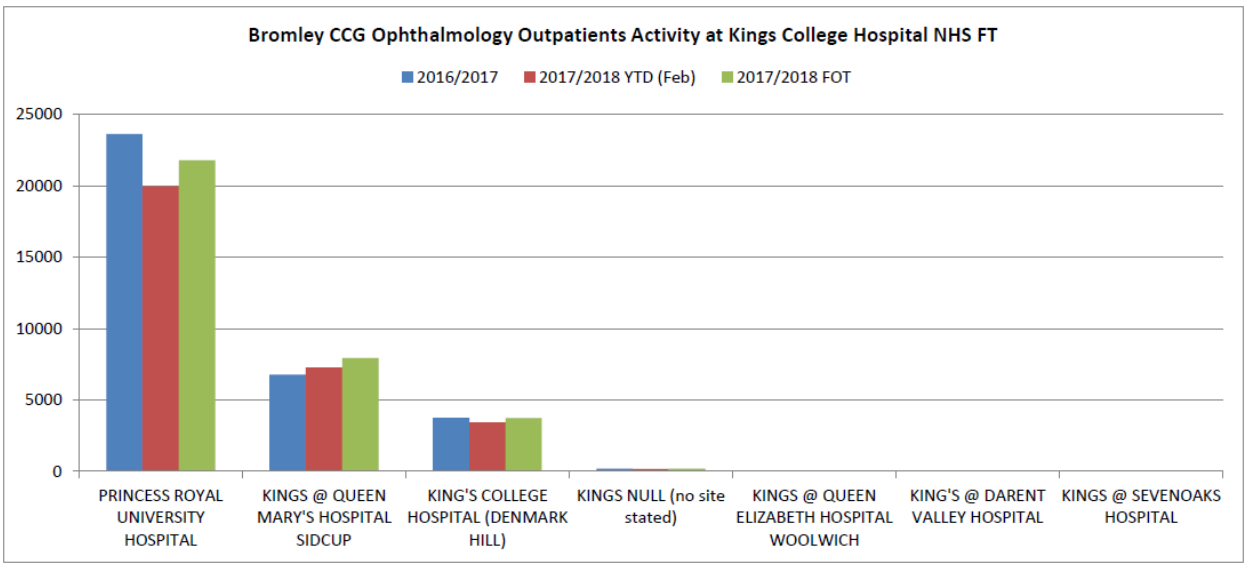


Figure 19 – Kings ophthalmology activity

Ophthalmology Outpatient Activity at KCH 2016/17 and 2017/18 YTD (Feb)			
KING'S COLLEGE HOSPITAL SITES	2016/2017	2017/2018 YTD (Feb)	2017/2018 FOT
PRINCESS ROYAL UNIVERSITY HOSPITAL	23606	19943	21756
KINGS @ QUEEN MARY'S HOSPITAL SIDCUP	6772	7278	7940
KING'S COLLEGE HOSPITAL (DENMARK HILL)	3757	3433	3745
KINGS NULL (no site stated)	191	182	199
KINGS @ QUEEN ELIZABETH HOSPITAL WOOLWICH	42	26	28
KING'S @ DARENT VALLEY HOSPITAL	11	0	0
KINGS @ SEVENOAKS HOSPITAL	41	0	0
Grand Total	**34420**	**30862**	**33668**

Table 4 - Kings ophthalmology activity

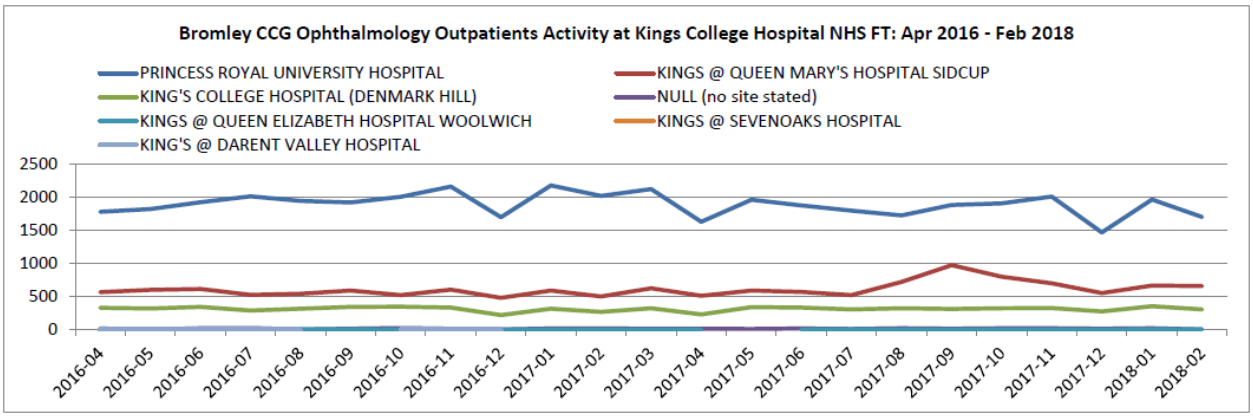


Figure 20 – Kings ophthalmology activity 2016 -2018

Ophthalmology Outpatient Activity by Attendance Type and Top Ten Provider 2016/17					
Provider	First	Follow-up	Procedure	Grand Total	1st: FUP Ratio
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	9157	15886	9377	34420	1:1.7
KINGS @ PRINCESS ROYAL UNIVERSITY HOSPITAL	4377	11599	7630	23606	1:2.6
KINGS @ QUEEN MARY'S HOSPITAL SIDCUP	4166	1892	714	6772	2.20:1
KING'S COLLEGE HOSPITAL (DENMARK HILL)	513	2230	1014	3757	1:4.3
KINGS NULL (no site stated)	53	135	3	191	1:2.5
KINGS @ QUEEN ELIZABETH HOSPITAL WOOLWICH	17	9	16	42	1.89:1
KINGS @ SEVENOAKS HOSPITAL	26	15	0	41	1.73:1
KINGS @ DARENT VALLEY HOSPITAL	5	6	0	11	1:1.2
MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST	1043	3209	2577	6829	1:3.1
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	364	855	668	1887	1:2.3
BMI HEALTHCARE	311	577	66	954	1:1.9
MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	152	161	37	350	1:1.1
QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST	8	111	13	132	1:13.9
IMPERIAL COLLEGE HEALTHCARE NHS TRUST	8	34	70	112	1:4.3
EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS	6	31	29	66	1:5.2
BARTS HEALTH NHS TRUST	7	23	12	42	1:3.3
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FT	7	27	4	38	1:3.9

Table 5 - Ophthalmology outpatients activity 2016/17

Data from 2016/17 (Table 5) to 2017/18 (Table 6) is suggesting that first ophthalmology outpatient appointment activity is very slightly down, but this is not significant. Reductions in referrals from primary care need to continue. This will not reduce overall HES activity but is essential to free up HES capacity in order to avoid harm from potential follow-up appointments delays. HES may need to employ use of virtual clinics to manage their increasing workload.

No serious incidents or complaints were received for the PEC/MECS pilot up to the end of the this audit period.

Ophthalmology Outpatient Activity by Attendance Type and Top Ten Provider 2017/18 YTD (Feb)					
Provider	First	Follow-up	Procedure	Grand Total	1st: FUP Ratio
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	7864	13614	9384	30862	1:1.7
KINGS @ PRINCESS ROYAL UNIVERSITY HOSPITAL	2884	9702	7357	19943	1:3.4
KINGS @ QUEEN MARY'S HOSPITAL SIDCUP	4401	1899	978	7278	2.32:1
KING'S COLLEGE HOSPITAL (DENMARK HILL)	523	1864	1046	3433	1:3.6
KINGS NULL (no site stated)	39	143	0	182	1:3.7
KINGS @ QUEEN ELIZABETH HOSPITAL WOOLWICH	17	6	3	26	2.83:1
KINGS @ SEVENOAKS HOSPITAL	0	0	0	0	0
KINGS @ DARENT VALLEY HOSPITAL	0	0	0	0	0
MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST	1106	2802	2491	6399	1:2.5
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	280	652	554	1486	1:2.3
BMI HEALTHCARE	403	615	85	1103	1:1.5
MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	81	111	35	227	1:1.4
QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST	8	95	13	116	1:11.9
IMPERIAL COLLEGE HEALTHCARE NHS TRUST	7	48	53	108	1:6.9
EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS	6	30	20	56	1:5.0
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FT	4	41	0	45	1:10.3
BARTS HEALTH NHS TRUST	7	23	14	44	1:3.3
Ophthalmology Outpatient Activity by Attendance Type and Top Ten Provider 2017/18 FOT					
Provider	First	Follow-up	Procedure	Grand Total	1st: FUP Ratio
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	8579	14852	10237	33668	1:1.7
KINGS @ PRINCESS ROYAL UNIVERSITY HOSPITAL	3146	10584	8026	21756	1:3.4
KINGS @ QUEEN MARY'S HOSPITAL SIDCUP	4801	2072	1067	7940	2.32:1
KING'S COLLEGE HOSPITAL (DENMARK HILL)	571	2033	1141	3745	1:3.6
KINGS NULL (no site stated)	43	156	0	199	1:3.7
KINGS @ QUEEN ELIZABETH HOSPITAL WOOLWICH	19	7	3	28	2.83:1
KINGS @ SEVENOAKS HOSPITAL	0	0	0	0	0
KINGS @ DARENT VALLEY HOSPITAL	0	0	0	0	0
MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST	1207	3057	2717	6981	1:2.5
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	305	711	604	1621	1:2.3
BMI HEALTHCARE	440	671	93	1203	1:1.5
MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	88	121	38	248	1:1.4
QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST	9	104	14	127	1:11.9
IMPERIAL COLLEGE HEALTHCARE NHS TRUST	8	52	58	118	1:6.9
EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS	7	33	22	61	1:5.0
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FT	4	45	0	49	1:10.3
BARTS HEALTH NHS TRUST	8	25	15	48	1:3.3

Table 6 - Ophthalmology outpatients activity 2017/18

All Bromley CCG Ophthalmology Outpatient Activity by Source of Referral			
Source of Referral	2016/2017	2017/2018 YTD (Feb)	2017/2018 FOT
Referral from a general medical practitioner	26180	23531	25670
Referral from a consultant, other than in an accident and emergency department	6953	6282	6853
Self-referral	3838	3428	3740
Referral from an accident and emergency department (including minor injuries units and walk in centres)	2809	2608	2845
Other - not initiated by the consultant responsible for the consultant out-patient episode	3048	2595	2831
Other - initiated by the consultant responsible for the consultant out-patient episode	1189	1220	1331
Following an accident and emergency attendance (including minor injuries units and walk in centres)	455	380	415
Referral from an optometrist	393	385	420
Referral from a national screening programme	139	166	181
Referral from an allied health professional	20	24	26
Following an emergency admission	31	45	49
Referral from a general dental practitioner	8	6	7
Referral from an orthoptist	12	7	8
Following a domiciliary consultation	14	8	9
NULL	2	2	2
Referral from a community dental service	0		0
Referral from a prosthetist	0	1	1
Referral from a specialist nurse (secondary care)	1	1	1
Grand Total	**45092**	**40689**	**44388**

Table 7 - Ophthalmology activity by source

Table 7 reporting is misleading as optometrist referrals are a primary source for at least 75-80% of referral activity by GPs.

9 Summary of actions for remainder of pilot

Based on a review of data, documentation and feedback, the following actions should be implemented for the duration of the eye care pilot:

ACTION 1: Further stakeholder engagement and communication with GP practices is required to promote the appropriate use of the MECS service.

ACTION 2: Activity appears to be to plan (Table 1, Appendix A), but there is a need to understand unwarranted variation of source of activity for two sites for conversion from sight test/ eye examination (Figures 5 & 6). This may be a reporting issue but requires the sharing of comparative data and discussion with the provider sites to ensure correct recording of episodes. [The Standard Operating Procedure for MECS practices has been updated to highlight scenarios of presentations which would apply].

ACTION 3: Implementation of glaucoma repeat measures (filtering) within MECS practices should be followed up as part of the contract.

ACTION 4: Need to maximise the capture of unrefined referrals via the SPA triage (sourced from GP referrals, and referrals sent to GP by non-MECS accredited (or locum) optometrists for onward referral to HES (both within and outside the CCG boundary). This includes any unrefined referrals from MECS practices (e.g. where glaucoma filtering has not been undertaken). Need to ensure completeness and readability of referral correspondence (includes visual fields) on e-RS.

ACTION 5: Attempt to minimise waits >4 weeks to ensure any 'referrals on' to the HES can be seen within the required 18 weeks target.

ACTION 6: All referrers to MECS to receive an outcome letter from MECS optometrist. Also, GPs **AND** optometrist referrers to receive an outcome letter from the MECS optometrist for any patient seen as a result of SPA triage.

General observations on referral quality and feedback loop:

- Good communication including referral feedback and information sharing are important in any integrated clinical pathway.
- Good quality referral information enables signposting of the patient into the appropriate community clinic or ophthalmology sub-speciality clinic at the first attempt. This reduces the number of appointments for the patient, improving the efficiency of the pathways.
- As more optometrists are now the primary referrer on e-RS, HES feedback or discharge summary letter should be to the referring optometrist and copied to the GP ***Action for CCG Contract board*** *– seek HES replies to referring optometrist, consider contractual requirement, trusts to add all SEL optical practices, and their addresses and contact details to their systems.*
- There should be more opportunities to bring together all practitioners involved in eye care for periodic Continuous Professional Development (CPD) sessions e.g. feedback on referrals, the type of information is most useful in a referral letter, current pathways and treatments for eye conditions and referral timescales for acute eye conditions.
- The SPA should make direct links with the SEL Diabetic eye screening programme (DESP). Greater communication between providers could reduce optometrist referrals for non-sight-threatening retinopathy for patients already under screening.
- SEL DESP to encourage patients to take eye screening result letter to NHS sight test.
- Pilot use of e-RS for advice and guidance.

10 Recommendations for April 2019 onwards

Recommendations and considerations for a future procurement/ contract specification:

RECOMMENDATION 1: Clarity over terminology: consider using 'Bromley Eye Care Services' in a new procurement as the title of the **overall contract specification**. MECS would still be outward facing for GPs and the main entry point for patients. Future contracts need to be flexible to include a wider range of services, as there are opportunities for further services to be added as the workforce develops e.g. cataract post-operative care, OCT for refinement of suspect retinal conditions. Service models are already developing into lower levels of community ophthalmology, and there is significant scope for stable AMD and stable glaucoma monitoring; these would not be considered appropriate under a 'minor condition' service (MECS).

RECOMMENDATION 2: The coverage map (Figure 3) suggests that additional PEC sites should be considered: one in Bromley, one in West Wickham and two in the Beckenham area, in order to provide improved access for patients, referrals from GP practices and cover for holidays**.** Over time, more local optical practices should be able to offer MECS and repeat measures, but optometrists managing low-risk referrals from SPA need to develop a greater level of skills and experience.

RECOMMENDATION 3: Quarterly meetings involving commissioners and providers to focus on the development of community ophthalmology service model involving primary and HES providers. Communication and closer liaison between primary eye care lead and HES lead. This could involve direct contact as required and separate one-to-one meetings to improve local issues.

RECOMMENDATION 4: Community ophthalmology model will require further development around failsafe (tracking of patients and outcomes) and workforce planning and training (e.g. informed by risk stratification of pathways) to provide assurance. The SPA could be used as a step-down route to provide such failsafe.

CONSIDERATION 1: Failsafe Action 3 on Demand and Capacity review should highlight issues requiring SAFE system changes, any contract to include review dates for changes to service specification.

CONSIDERATION 2: Alignment and agreement of SEL whole system wide pathways (priority) e.g. risk stratification of Glaucoma pathway, as per NICE guidance and Cataract post-assessment/ NOD data as recommended in Monitor productivity report 2015. Wherever possible, there should be alignment of PEC service specifications and related exclusion criteria.

CONSIDERATION 3: SEL governance arrangements should include procedures for prospective evaluation of the design and delivery of whole eye care pathways (across primary, secondary and social care) which demonstrate: more appropriate and effective patient management, patient safety, clinical audit, competence of the workforce, and high levels of patient experience.

CONSIDERATION 4: Include Healthy Living Opticians within next PEC specification where optical practices are able to offer, or direct to: Smoking Cessation Services. Alcohol Screening, NHS Health Checks including glucose testing and cholesterol, Weight Management. Health Living Opticians is a strategy that started in the borough of Dudley which has gained national attention. http://dudleyhlo.co.uk/wp-content/uploads/2015/10/Dudley-HLO-Prospectus-FINAL.pdf

and promote South London Innovation Network - VISIBLE recommendations to link vison and falls services. *https://healthinnovationnetwork.com/visible/*

11 Conclusions

1. The Bromley CCG eye care pilot is mid-way through its contract period and has already made an impact on improving referral quality and reducing inappropriate referrals.

2. This report highlights the benefits of the PEC service model with SPA function and provides actions for the current pilot and recommendations for full procurement at a future date.

3. More engagement and communication are necessary to promote the MECS service to GPs, to optometrists (outside the PEC service) and to patients. These are similar findings to Cottier (2015).[30]

4. Contract monitoring should continue to inform any future procurement decisions.

5. This area of service redesign is still evolving. Future developments are possible and desirable. Any future contract should be flexible with regular annual reviews to allow for the development and roll out of further eye care initiatives.

6. Action 3 of HII requires CCGs/STP leaders to undertake an eye health capacity review in 2018 in order to understand the demand for eye services; the outcomes of this exercise should inform a wider eye health strategy for SEL.

7. It is too early to generate financial assumptions based on six-months data in year 1, but the report's findings are extremely encouraging. Assuring local HES capacity must remain a priority, improving flows within the whole pathway by 1) reducing unnecessary referrals and 2) allowing step-down for the management of patients with stable long-term eye conditions.

8. HES to provide feedback and communication with primary eye care by sending the outcome letter to the referring optometrist/ optical practice. A reply to the primary referrer is necessary for continuity of care (ophthalmologist to confirm patient consent at the end of the ophthalmology appointment). HES to report examples of unwarranted referral variation by source to the CCG. All optical practices should be encouraged to use NHS.mail and this would facilitate the receiving of referral outcome letters. HES would require a database containing information of all SEL optical practices.

9. Step-down or community ophthalmology pathways require system agreement by all relevant stakeholders. Actions 1 and 2 from the failsafe audit should assess follow-up patients according to risk. Some of the low-risk patients may be suitable for discharge, while other low-risk stable patients may be more suitable for community monitoring by a multi-professional team.

10. Data from the two-year pilot should be used as the basis for a research paper highlighting the integrated approach of the PEC framework, and the use of MECS in the wider context of triage and managing unwarranted variation.

12 References

1. NICE Glaucoma: diagnosis and management [NG81] (2017). Available online: https://www.nice.org.uk/guidance/ng81/chapter/Recommendations

2. NHS Digital: General Ophthalmic Services Activity Statistics. Available online: https://files.digital.nhs.uk/publication/f/d/gene-opht-serv-acti-eng-year-end-mar-17-rep.pdf

3. NHS Digital: Hospital Episode Statistics - Outpatient Activity. Available online: http://content.digital.nhs.uk/article/2021/Website-Search?q=title%3a+%22hospital+outpatient+activity%22&sort=Most+recent&size=10&page=1&area=both#top

4. NHS Digital: Hospital Episode Statistics – Admitted Patient Care. Available online: http://content.digital.nhs.uk/searchcatalogue?q=title%3A%22Hospital+Episode+Statistics%2C+Admitted+patient+care+-+England%22&area=&size=10&sort=Relevance

5. Rapid Response Report: NPSA/2009/RRR004: Preventing delay to follow up for patients with glaucoma. June 2009. Available online: http://www.nrls.npsa.nhs.uk/alerts/?entryid45=61908

6. Care Quality Commission: Cambridge University Hospitals NHS Foundation Trust – Quality Report. September 2015. Available online: https://www.cqc.org.uk/sites/default/files/new_reports/AAAD0111.pdf

7. Care Quality Commission: Royal Cornwall Hospitals special measures. October 2017. Available online: https://www.cqc.org.uk/news/releases/cqc-recommends-royal-cornwall-hospitals-should-go-special-measures

8. Parliamentary Questions: Eye sight: Health Services: Written Question 33459 – 11 April 2016. Available online: http://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2016-04-11/33459/

9. Parliamentary Questions: Ophthalmology: Written question 41184 – 24 June 2016. Available online: http://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2016-06-24/41184

10. Parliamentary Questions: Ophthalmology: Written question 51808 – 3 November 2016. Available online: http://www.parliament.uk/written-questions-answers-statements/written-question/commons/2016-11-03/51808

11. Foot B, MacEwen C. Surveillance of sight loss due to delay in ophthalmic treatment or review: frequency, cause and outcome. *Eye* 2017 May,31 (5); 771-775

12. London Assembly health committee report on eye-health preventing sight loss. Online: https://www.london.gov.uk/about-us/london-assembly/london-assembly-publications/eye-health-preventing-sight-loss-london

13. Get it right first time - Available online: https://www.rcophth.ac.uk/professional-resources/getting-it-right-first-time-for-ophthalmology/

14. Elective Care High Impact Intervention. Available online: https://www.england.nhs.uk/elective-care-transformation/events-webinars-and-webexes/

15. Systems and Assurance Framework for Eye-health (CCEHC 2018). Available online: http://ccehc.org.uk

16. Portfolio of Indicators for Eye Health and Care (VISION UK) 2018. Available online: http://ccehc.org.uk

17. Primary Eye Care Framework (CCEHC 2018): Available online: http://ccehc.org.uk

18. Davey CJ, Scally AJ, Green C, Mitchell ES & Elliott DB. Factors influencing accuracy of referral and the likelihood of false positive referral by optometrists in Bradford, United Kingdom. *Journal of Optometry* 2016; 9:158–165.

19. Konstantakopoulou, E. et al., 2016. Evaluation of a minor eye conditions scheme delivered by community optometrists. *BMJ Open*, 6(8).

20. Baker, H., Harper, R.A., et al., 2016. Multi-stakeholder perspectives of locally commissioned enhanced optometric services. *BMJ Open*, 6(10).

21. Mason, T. et al., 2017. Retrospective economic analysis of the transfer of services from hospitals to the community: an application to an enhanced eye care service. *BMJ Open*, 7(7).

22. NICE Quality and Productivity - Proven Case Study: Available online: https://www.nice.org.uk/guidance/qs7/resources/qipp-case-study-avoiding-unnecessary-referral-for-glaucoma-use-of-a-repeat-measurement-scheme-110018-485840557

23. NICE Glaucoma Quality standards Available online: https://www.nice.org.uk/guidance/QS7/chapter/Quality-statement-2-Referral

24. Learning disabilities pathway Available online: http://www.locsu.co.uk/uploads/enhanced_pathways_2013/locsu_pwld_pathway_rev_nov_2013.pdf

25. Monitor - Helping NHS providers improve productivity in elective care. Available online: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/466895/Elective_care_main_document_final.pdf Monitor

26. NOD, 2017. National Ophthalmology Database Audit. Available online: https://www.nodaudit.org.uk/

27. Community Ophthalmology Framework (CCEHC): Available online: http://ccehc.org.uk

28. London Eye Health Network: Achieving better outcomes report. Available online:http://www.londonsenate.nhs.uk/wp-content/uploads/2015/07/Item-5-2015-07-21-LCSC-Final- London-Eye-Health-Network-Achieving-Better-Outcomes.pdf

29. Cottier, K. 2015. An audit of the Primary Eye-care Acute Referral Scheme (PEARS) within NHS Bromley Clinical Commissioning Group (CCG), *Optometry in Practice*, 16:1. Available online: https://www.college-optometrists.org/oip-resource/an-audit-of-the-primary-eye-care-acute-referral-scheme--pears--within-nhs-bromley-clinical-commissioning-group.html

30. NICE CKS Management of suspected retinal detachment. Available online: https://cks.nice.org.uk/retinal-detachment#!scenario

13 Glossary

The following definitions are taken from the CCEHC SAFE documents.

Service System

A service system includes the range of pathways of care delivering services that may involve multiple providers and settings, to address the health needs of a defined patient population or condition.

General Ophthalmic Service (GOS)

The GOS is commissioned by NHS England. This contracts primary care opticians' practices to provide NHS sight tests for preventative and corrective eye care for children, people aged 60 and over, adults on low incomes and those suffering from, or predisposed to, eye conditions and diseases.

Primary Eye Care Framework

This service is commissioned by CCGs. It includes supplementary services that are necessary **prior to referral** for specialist ophthalmic opinion (usually within the Hospital Eye Service), thereby improving the quality of referrals. A primary eye care service will typically include the ability to:

- conduct supplementary checks to confirm abnormal test results (detected by a NHS eye test / eye examination) e.g. repeat measures as outlined in NICE Glaucoma Guideline NG 81.
- further refine the decision to refer e.g. where risks and benefits are discussed with the patient prior to referral for cataract surgery
- address the needs of a patient presenting with an acute eye condition (first contact)
- manage a range of low-risk primary eye conditions

Community Ophthalmology Framework

This service is commissioned by CCGs. It involves the assessment and management of patients whose eye conditions are at low-risk of deterioration who are **either referred by primary care for further assessment or discharged from secondary care for monitoring**, in order to release capacity and improve patient flows within the system. It has some or all of the following characteristics:

- the ability to make definitive diagnoses to manage and treat the majority of cases referred into it
- be effective as a monitoring service for patients at risk of their condition deteriorating asymptomatically
- provides an access point for patients with recurrent symptomatic disease.

Hospital Eye Service

This service is commissioned by CCGs. It provides specialist ophthalmic services for acute and chronic care for diagnosis, intervention and management; and emergency and urgent eye care.

Appendix A – Service activity data

BMECS 2017-18

Triaged to service or booked to

Total number of patient episodes incl. 1st appointments awaiting

Number of patients seen in each pathway

Number of follow-ups by pathway

Number of onward referrals after being seen in BMECS

Number of patients seen within 4 weeks – KPI 90%

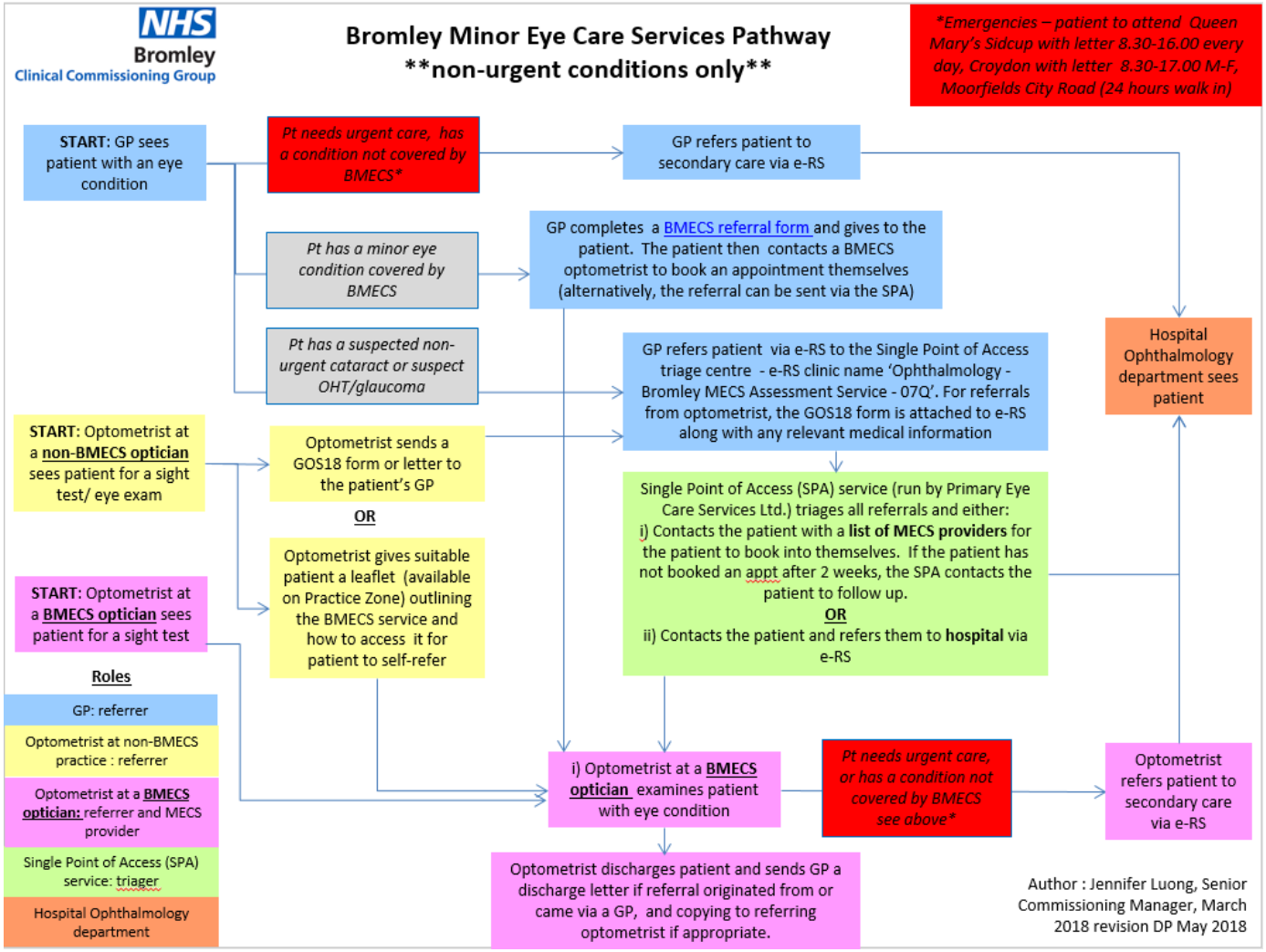
Number of DNAs

Number of discharge summaries sent to GP within 5 working days

Month	SPA	Referred to:		Total px episodes	Px seen				Follow-ups (booked)								Onward referrals						<4 weeks		DNA		Discharge summaries	
		Sec Care	BMEC		MECS (1st+fu)	MECS 1st	Glauc	Cat	MECS	%	Glauc	%	Cat	%	Total fu (KPI <30%)	%	MECS	%	Glauc	%	Cat	%	Activity	%	Activity	%	Activity	%
April																												
May				17																								
June				23																								
July				75																								
Aug				118																								
Sept	221	163	58	124	108	101	7	13	15	15%	1	14%	0	0%	16	13%	24	22%	0	0%	8	62%			0	0%	43 / 70	61%
Oct	301	240	61	196	155	138	21	20	18	13%	2	10%	0	0%	20	10%	26	17%	7	33%	19	95%	186	95%	0	0%	59 / 64	92%
Nov	343	226	117	248	184	170	29	35	17	10%	1	3%	0	0%	18	7%	28	15%	11	38%	32	91%	236	95%	0	0%	66 / 68	97%
Dec	236	179	57	200	163	149	23	14	17	11%	2	9%	0	0%	19	10%	28	17%	2	9%	12	86%	194	97%	0	0%	70 / 70	100%
Jan	293	230	63	296	240	223	32	24	41	18%	9	28%	0	0%	50	17%	37	15%	6	19%	20	83%	290	98%	0	0%	67 / 75	89%
Feb	235	181	54	293	245	223	28	20	21	9%	2	7%	0	0%	23	8%	38	16%	7	25%	20	100%	285	97%	0	0%	60 / 70	86%
Mar	240	189	51	370	287	269	50	33	44	16%	6	12%	0	0%	50	14%	44	15%	13	26%	28	85%	336	91%	0	0%	97 / 104	93%

Appendix B – GP/ Optometrist Pathway

Updated May 2018



Appendix C Standard Operating Procedure for MECS practices

Patients self-referring or directed by GP to MECS

Patients may self-refer, typically for the eye conditions below, or be directed by a GP or other health care professional. They should be booked with appropriate timescales based on presenting symptoms.

Patients converted from sight test to MECS

If it becomes clear during a NHS sight test that a patient is presenting with conditions such as:

- Red eye
- Sticky, yellow or watery discharge
- Pain or discomfort in eyes
- Recent onset or sudden increase of flashes of light and/or floaters

and it is more appropriate for the patient to be seen in the MECS pathway, then the NHS sight test should be abandoned and a MECS assessment completed. The NHS sight test if still needed can be re-booked for another occasion. If the MECS examination finds the need for the measurement of IOP by GAT on first occasion or cataract refinement, these should be done within and as part of the MECS appointment and not as a separate claim.

Addition to the sight test

If the patient need to be assessed for cataract referral or needs glaucoma repeat measures, then this is to be carried out as an addition to the sight test. Repeat measures may require the patient to return on another occasion.

Important: if a patient is seen by a non-accredited practitioner (e.g. newly qualified or locum) in a MECS Practice but is deemed suitable for one of the pathways, then they should be referred within the practice for the MECS, cataract, or glaucoma repeat measures assessment to take place as per contract.

Patients referred from triage

Patients who have been referred to hospital will be triaged by an optometrist at the Single Point of Access (SPA). If the patient is deemed suitable to be seen in the MECS service, then they will be sent a letter (overleaf) offering a choice of providers. The patient will then phone their choice of provider to make an appointment. You can check that the patient has come from this source by asking for their UBRN number.

To access the original referral, those who have smartcards and have received training, will be able to retrieve from the e-referrals system. Those who are not at this stage will need to request the information from the SPA. This should be requested by email to broccg.bbgspa@nhs.net with as much notice as possible. The request should include the patient's name, date of birth, and UBRN as well as the date and time of appointment. The original referral information will be emailed back along with the triager's comments.

Onward referrals

Those with smartcards that have received training will be able to refer direct on e-RS. Those who are not should email any onward referrals to broccg.bbgspa@nhs.net who will process this on your behalf. Please note in your email which clinic the patient should be referred to.

Urgent referrals

Any urgent referrals that are not same day (i.e. possible wet AMD) should be emailed directly to the PRUH or QMS using an nhs.net email address

The email needs to be marked **** URGENT OPHTHALMOLOGY REFERRAL AGREEMENT TO REFER OUTSIDE E-RS **** NAME – DOB

For PRUH: kch-tr.br-referrals@nhs.net

For QMS (Queen Mary Sidcup): Kch-tr.urgenteyesqms-referrals@nhs.net

Queries

Please direct any queries for broccg.bbgspa@nhs.net or call 020 3876 4931

Appendix D Patient invite letter

<<date4>>

Dear <<Title>> <<Surname>>

UBRN Number: <<UBRN>>
Password: <<password>>

We have recently received a referral letter for you from your GP/optometrist. We are pleased to let you know that your condition has been deemed suitable for the specialist clinics run by the Bromley Minor Eye Conditions Service.

The Bromley Minor Eye Conditions Service provides patients experiencing certain eye conditions with appropriate treatment closer to home. The service is provided by local optometrists with the specialist knowledge and skills to carry out this work at a locally approved optical practice.

All you need to do is call one of the approved opticians practices listed overleaf and book yourself an appointment. You will require your UBRN number and password as detailed above.

It is imperative when contacting the opticians to make an appointment that you state that you have been referred by your GP/optometrist and you are to be seen under the Bromley Minor Eye Conditions Service.

Yours sincerely

Bromley Eye Care Services
Tel: 020 3876 4931

Appendix E Booking a MECS appointment

Booking of Bromley Minor Eye Conditions Service (BMECS) appointment

Please contact one of the local optometrists listed below, who will offer you an appointment. Inform the optometrist's receptionist that this is a request for a BMECS appointment and be sure to take this referral form with you when you attend.

Please note that as part of your examination, eye drops may be used to enable examination of the eyes. If drops are used, they will temporarily affect the ability to focus properly so you will not be able to drive for approximately 4 hours after your eye examination or until your vision has recovered. Your eyes may also, temporarily, become more sensitive to light so you may wish to wear sunglasses to relieve this.

Hayes Optical - Boots Opticians 2 Station Buildings, Station Approach, **Hayes**, Kent BR2 7EN Tel No: 020 8462 5332 *BMECS service availability: Monday to Saturday: 9pm to 5pm*	**Boots Opticians** 40 The Glades, **Bromley**, BR1 2QG Tel No: 020 8460 4944 *BMECS service availability: Monday to Friday: 9am - 5.30pm*
Boots Opticians 232 High Street, **Orpington**, Kent BR6 0LS Tel No: 01689 820848 *BMECS service availability: Tuesday, Wednesday, Thursday & Saturday: 8.30am–5pm*	**Boots Opticians** 115 Station Road, **West Wickham**, Kent BR4 0PX. Tel No: 020 8777 2211 *BMECS service availability: Monday, Tuesday, Wednesday, Thursday & Saturday: 9am-12pm & 2pm–5pm, Friday: 9am–12pm & 3pm–5pm*
Linklater & Warren Opticians 30A High Street, Chislehurst, **Bromley**, Kent BR7 5AN Tel: 020 8295 5131 *BMECS service availability: Monday-Friday: 9am - 5.30pm, Saturday: 9am -2pm*	**Oakmead Opticians** Sunnyways, Prince Imperial Rd, **Chislehurst** BR7 5LX Tel: 020 8467 5139 *BMECS service availability: Mon 8am-7.30pm, Tue 8am-7pm, Wed 8.30am-8pm, Thurs 10am-8pm, Fri 8am-5.30pm, Sat 9am -1pm*
Ellis & Edwards Opticians 254 High Street, **Beckenham**, Kent BR3 1DZ Tel: 020 8658 2313 *BMECS service availability: Monday, Thursday and Friday 9am to 4pm.*	**Specology** 160 Main Road, Biggin Hill, Kent, TN16 3BA Tel: 01959 9280 *BMECS service availability: 9am to 5pm Tuesday to Friday; 10am to 4pm Saturday (closed Monday and Sunday)*
Specsavers 169 High St, **Orpington**, Kent BR6 0LW Tel: 01689 890168 *BMECS service availability: Monday, Tuesday, Wednesday, Friday and Saturday: 9.30am-5pm*	

Appendix F NHS e-RS ophthalmology booking guidance

Ophthalmic clinics

There are 13 possible clinic types within the HES that Ophthalmic patients can be referred into. If there is more than one appropriate clinic i.e. patient has Cataract and Glaucoma please direct into the one you are most concerned about.

List of possible clinics:

Oculoplastic/Orbits/Lacrimal	Cornea	Cataract
Laser (YAG)	Vitreoretinal	Diabetic Medical Retina
Other Medical Retina	Glaucoma	Low Vision
Orthoptics	Squint/Ocular Motility	External eye disease
Oncology (established diagnosis)		

****Please note DO NOT USE "not otherwise specified". There is also no option to book into neuro-ophthalmology. Please choose most suitable so that patient is seen in the HES.**

e-Referrals can have one of 2 possible outcomes:

Urgent (6 weeks)	Routine (13 weeks)

There is no option for "soon". Once a hospital receives a referral it may bring that referral forward after carrying out its own triage.

Those referrals which require to be prioritised as more urgent referrals (ie those to be seen within 2 weeks e.g. suspect wet AMD) are emailed direct to either PRUH or QMS.

[For same day emergency referrals, patients need to be directed with a letter to the most appropriate site – QMS rapid access clinic with letter or a walk-in hospital eye casualty].

The email needs to be marked **** URGENT OPHTHALMOLOGY REFERRAL AGREEMENT TO REFER OUTSIDE E-RS **** NAME – DOB

For PRUH: kch-tr.br-referrals@nhs.net

For QMS (Queen Mary Sidcup): Kch-tr.urgenteyesqms-referrals@nhs.net

Issues with booking into e-RS

Some clinics are not what we think they are…

If you see referrals for the following, please can you book into these clinics:

Clinic type on e-RS	Conditions covered
Cornea	Anything corneal related
Oculoplastics	Entropion, ectropion, ptosis, lid lesions i.e cysts etc and bells palsy
External eye disease	Corneal, external eye disease, conjunctival conditions (does not cover cysts, lumps and bumps and lacrimal/lid misposition)

Appendix G Triage guidance

Condition	Referral Criteria
Cataracts	VA of 6/12 or worse in either eye OR Symptomatic AND Ideally, patient has indicated they want to have surgery
Glaucoma	NICE IOP referral criteria on IOP alone is 24mmHg or above by Goldmann-type tonometry as per NICE guidelines Nov 2017) NCT between 24 and 29mmHg, and no other signs, refer to MECS optom for enhanced case finding using Goldmann tonometry. Refer on if average IOP by any other method is over 29mmHg. Other referral criteria: Repeatable field defect by suprathreshold visual fields– refer on, Refer to MECS optom is visual field defect is only found on FDT and NCT IOP is between 24 and 29mmHg inc. Disc asymmetry and signs of glaucoma disc change is not just about CD ratio but barring of blood vessels, ISNT not met. Disc haem - refer Narrow angles – refer on for gonioscopy
Dry AMD	Presence of oedema, haemorrhages Symptoms of metamorphopsia Sudden reduction in vision
Naevi	All suspicious lesions to be referred (additional referral guidance required – after further discussion with Kings/ G&T) Descriptions of large and elevated, location in relation to the Optic Disc
Flashes and Floaters	If referral is from GP/ Optom and there has been no dilated fundal examination using SL-BIO, refer to MECS 24hrs, If onset is within 4 weeks of referral date and patient has already had dilated assessment and has been referred– refer URGENT If onset over 4 weeks (any source) refer into MECS (< & > 4 weeks requires further discussion with Kings/ G&T)
Keratoconus	Refer into HES
Styes and Cysts	Refer into MECS – only to be referred when treatment has not worked.
Blepharitis and Dry Eye	Refer into MECS only if recent onset – to be referred to HES if longstanding (e.g. over 3 months) when compresses and/or other treatments have not worked.
Orthoptics	This is with team of orthoptists only – this is not a consultant led service – if patient requires further investigation into squint, diplopia etc please book into Squint/Ocular Motility clinic
Blurred disc margins	Very urgent referrals (requires further discussion with Kings/ G&T)

With any referral please use your clinical judgement to decide upon most appropriate course of action for patient.

Evidence for the Action[30]

Immediate referral to ophthalmology - Evidence for change

Management: How should I manage a person with suspected retinal detachment?

The urgency of specialist assessment depends on whether there are changes in visual acuity, visual field loss, or signs seen on fundoscopy.

- ***If the person is experiencing new-onset flashes and/or floaters, refer them immediately to an ophthalmologist to be seen on the same day*** *if there are signs of sight-threatening disease, such as:*
  - *Visual field loss (such as a dark curtain or shadow), or distorted or blurred vision.*
  - *Fundoscopic signs of retinal detachment or vitreous haemorrhage.*
- ***If the person is experiencing new-onset flashes and/or floaters, refer them urgently to a practitioner competent in the use of slit lamp examination and indirect ophthalmoscopy, to be seen within 24 hours*** *if there is:*
  - *No visual field loss.*
  - *No change in visual acuity.*
  - *No fundoscopic signs of retinal detachment or vitreous haemorrhage.*
- ***Considering offering the person a patient information leaflet*** *about retinal detachment and the early warning signs of possible future retinal tear or detachment, such as that published by the Royal College of Ophthalmologists and the Royal National Institute of Blind People Understanding retinal detachment.*

Immediate referral to ophthalmology

- *The recommendation to refer a person immediately to ophthalmology if they present with signs of sight-threatening disease is based on expert opinion in the College of Optometrists Guidance for professional practice [The College of Optometrists, 2014], the Local Optical Committee Support Unit Flashes and Floaters Management Guidelines [LOCSU, 2013], and expert opinion in a number of review articles [Gariano and Kim, 2004; D'Amico, 2008; Kang and Luff, 2008].*
  - *Signs of a visual field defect but preserved visual acuity suggests that the macula is not yet detached, and early intervention with timely surgery may prevent macular detachment and improve visual outcomes [Gariano and Kim, 2004].*
  - *If the person presents with vision loss, this suggests retinal detachment or vitreous haemorrhage is present, and signs of retinal break or detachment are likely, so the person should be assessed urgently by ophthalmology [LOCSU, 2013].*

Urgent assessment by a practitioner competent in the use of slit lamp examination and indirect ophthalmoscopy

- *The recommendation to refer a person urgently to a competent practitioner within 24 hours if they present with only floaters and/or flashes and no other signs or symptoms is based on expert opinion in the Royal College of Ophthalmologists guidance Management of acute retinal detachment [Royal College of Ophthalmologists, 2010], in the Local Optical Committee Support Unit Flashes and Floaters Management Guidelines [LOCSU, 2013], and in a British Medical Journal review article Management of retinal detachment: a guide for non-ophthalmologists [Kang and Luff, 2008].*
    - *Retinal breaks and tears may initially present with symptoms of flashes and/or floaters, and early detection and treatment may prevent subsequent retinal detachment. Retinal detachment cannot be excluded using direct ophthalmoscopy in primary care, as this gives a narrow field of view. Specialist slit lamp examination is needed to look for pigment cells within the vitreous and vitreous haemorrhage, and indirect ophthalmoscopy is needed to examine the peripheral retina fully to determine whether posterior vitreous detachment, retinal breaks, or retinal detachment are present [Kang and Luff, 2008; Royal College of Ophthalmologists, 2010].*
    - *Competent practitioners can check for retinal breaks, tears, or detachment without the need for initial ophthalmology assessment if the person presents with non-sight-threatening symptoms and signs.*

Offering patient information

- *The recommendation to consider offering the person a patient information leaflet about retinal detachment and its early warning signs is based on expert opinion in the College of Optometrists Guidance for professional practice [The College of Optometrists, 2014], the Local Optical Committee Support Unit Flashes and Floaters Management Guidelines [LOCSU, 2013], and is based on what CKS considers to be good medical practice.*

Appendix H Patients not booked SOP

Similar arrangements should be agreed across all 6 CCGs.

Bromley

MECS appointments

- After 4 weeks, patient to be called up to 3 times
- If patient has been seen or no longer requires appointment they will be either allocated to the practice they were seen at on e-RS or cancelled on e-RS
- If patient still wishes to be seen, they will be given UBRN etc if needed
- If patient cannot be contacted by phone, letter stating that they will be considered not to require their appointment unless they contact the SPA within 2 weeks
- If still no contact, patient removed from e-RS and GP advised

Hospital choice given

- Patient receives to automated reminders from e-RS
- After 3 months, patient removed from e-RS and GP written informed

Appendix I Service specification (separate file)

London Borough of Bromley

PART 1 - PUBLIC

Decision Maker:	**HEALTH SCRUTINY SUB-COMMITTEE**
Date:	**17th October 2018**
Decision Type:	Non-Urgent Non-Executive Non-Key
Title:	**WINTER PLANNING**
Contact Officer:	Clive Moss, Urgent Care Lead, Bromley Clinical Commissioning Group Tel: 07864 969 693 E-mail: clive.moss@nhs.net
Chief Officer:	Dr Angela Bhan, Bromley Clinical Commissioning Group
Ward:	NA

1. Reason for report

1.1 This report is to provide an update on the development of a Bromley System Winter Plan to the Health Scrutiny Sub-Committee.

1.2 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, South East London Sustainability and Transformation Partnership (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. RECOMMENDATION

2.1 The Health Scrutiny Sub-Committee is requested to note the update.

Corporate Policy

1. Policy Status: Existing policy.
2. BBB Priority: Supporting Independence.

Financial

1. Cost of proposal: Estimated cost ,647,000: £628k (CCG) £1,027k (LBB), £992k (King's)
2. Ongoing costs: Non-recurring cost.
3. Budget head/performance centre: LBB/ CCG/ King's
4. Total current budget for this head: See above.
5. Source of funding: Better Care Fund

Staff

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

Legal

1. Legal Requirement: N/A
2. Call-in: Call-in is not applicable. No Executive decision.

Customer Impact

1. Estimated number of users/beneficiaries (current and projected): 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 appropriate resource for frail and elderly residents who are particularly vulnerable to seasonal illness.

Ward Councillor Views

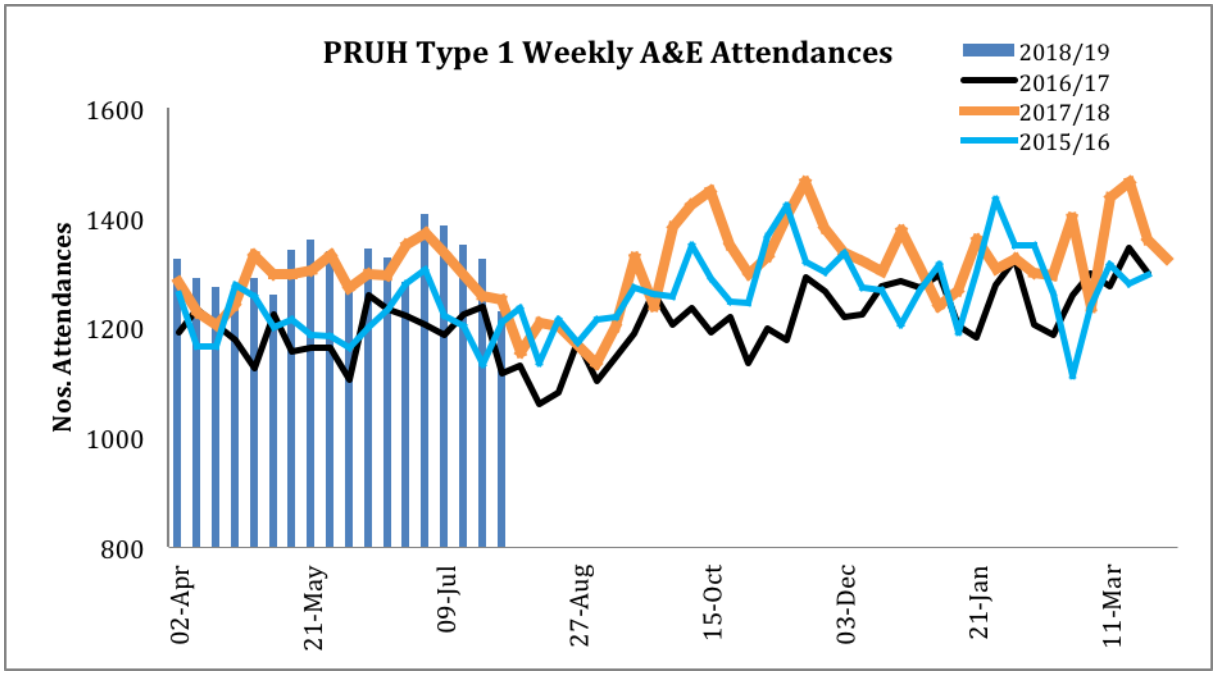
1. Have Ward Councillors been asked for comments? N/A.
2. Summary of Ward Councillors comments: Plan has been to Health and Wellbeing Board for comment.

3. COMMENTARY

3.1 BACKGROUND

3.2 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:



3.3 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.

3.4 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.

3.5 AIMS AND OBJECTIVES

3.6 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:

3.6.1 **Surge Management:**

- 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 utilised 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

3.6.2 **Winter Resilience Schemes 18/19**

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.

Each scheme will have a robust monitoring and evaluation process ensuring that the agreed KPIs are delivered. LBB are replicating similar activity from the previous year following positive evaluation of the impact of this resource.

The CCG winter resilience funding (£628k budget) and London Borough of Bromley winter resilience scheme funding (£1027k) have therefore 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).

King's College Hospital NHS Foundation Trust have also submitted their proposed winter schemes (£992k) which are being signed off internally. A full list of the schemes including financial investment and KPIs can be found in the 'Overall Winter Scheme Spend' appendix.

3.6.3 **Further System Winter Planning:**

This includes:

- Infection Control including Flu vaccination plans from providers
- Processes for hospital repatriations
- Improving ambulance handover workstreams

- Minor Breach Reduction work planning.
- Out of Hospital Borough-Based Service Map
- Additional Winter planning

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.

4. POLICY IMPLICATIONS

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

5. FINANCIAL IMPLICATIONS

5.1 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

Non-Applicable Sections:	Personnel and 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

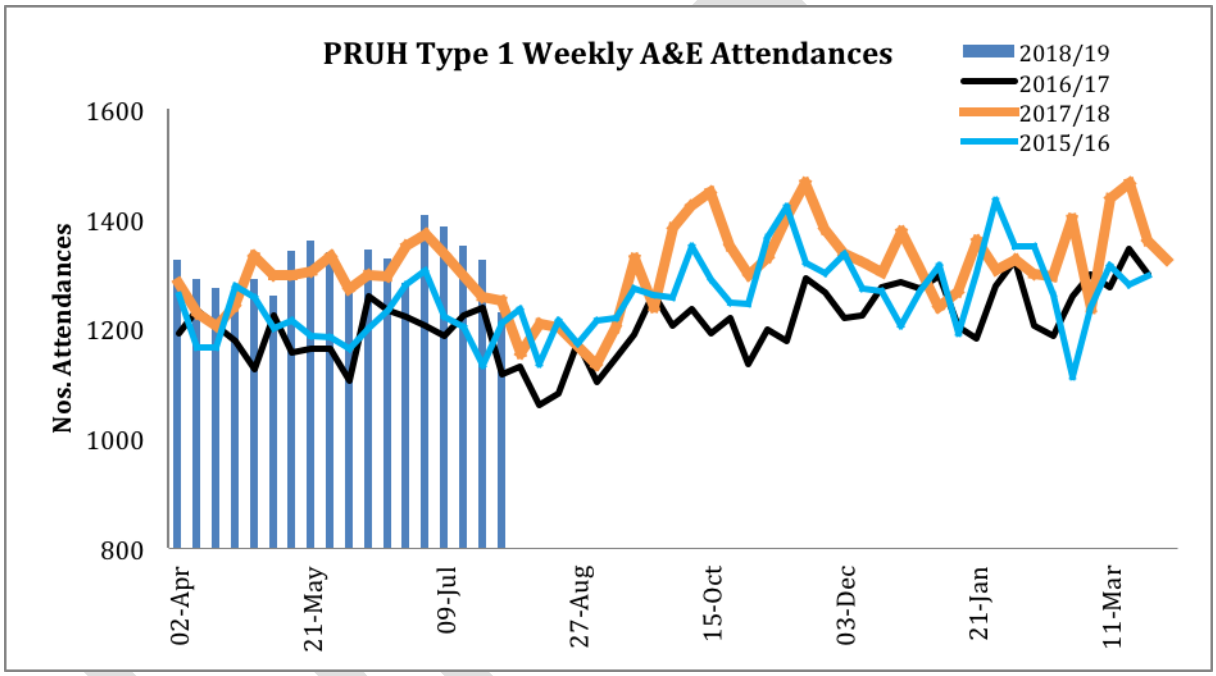
1 CONTENTS

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:

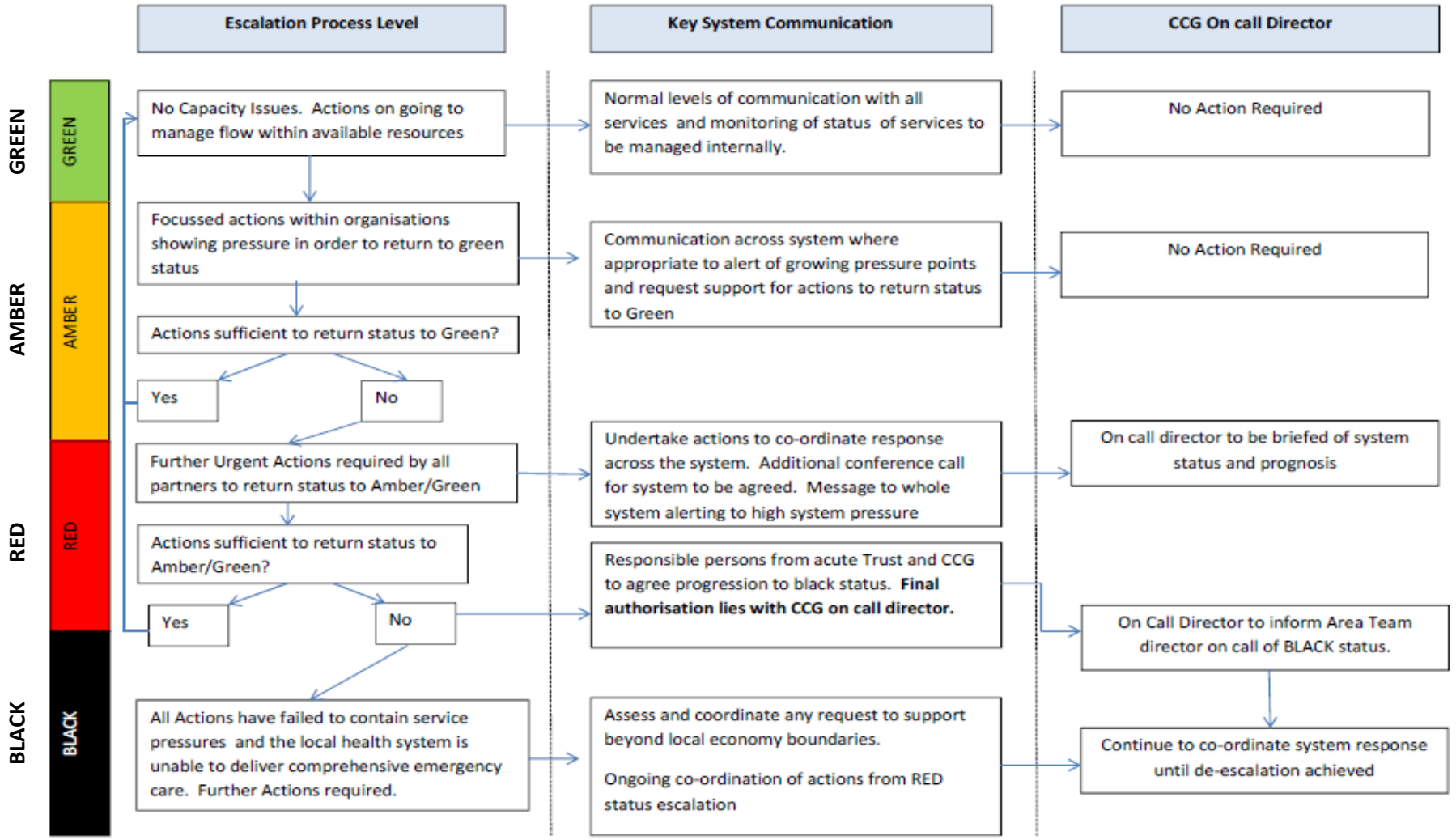
- Severe winter weather
- Heatwave conditions
- A Major Incident with severe and multiple casualties
- Pandemic influenza or other infectious disease outbreaks
- Disruption to community care and/or social care services
- Extended Bank Holiday Weekends causing increased demand on both Acute Trust and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

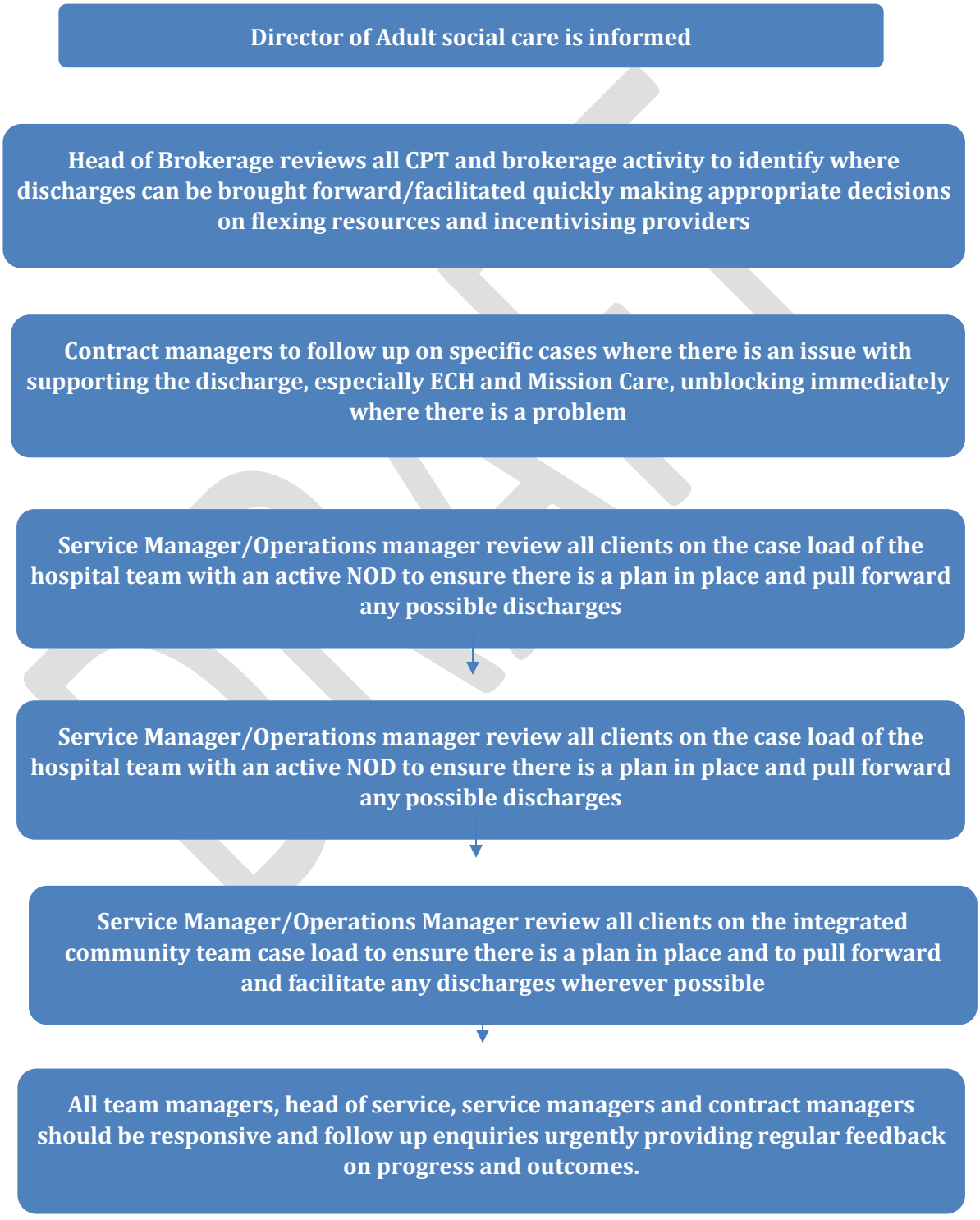
BHC report on the outcome of the 0830 and 0930 calls internally and any surge requirements are escalated through AD Ops to Director of Ops to CEO accordingly. BHC will dial into platinum calss when required.

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

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**							

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.
CSD18125

London Borough of Bromley

PART ONE - PUBLIC

Decision Maker:	**HEALTH SCRUTINY SUB-COMMITTEE**
Date:	**Wednesday 17th October 2018**
Decision Type:	Non-Urgent Non-Executive Non-Key
Title:	**WORK PROGRAMME 2018/19**
Contact Officer:	Kerry Nicholls, Democratic Services Officer Tel: 020 8313 4602 E-mail: kerry.nicholls@bromley.gov.uk
Chief Officer:	Director of Corporate Services
Ward:	N/A

---

1. Reason for report

1.1 The Health Scrutiny Sub-Committee is requested to consider its work programme for 2018/19.

---

2. RECOMMENDATION

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

Impact on Vulnerable Adults and Children

1. Summary of Impact: Not Applicable

Corporate Policy

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

Financial

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

Personnel

1. Number of staff (current and additional): 8 staff (6.87fte)
2. If from existing staff resources, number of staff hours: N/A

Legal

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

Procurement

1. Summary of Procurement Implications: None

Customer Impact

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

Ward Councillor Views

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

3. COMMENTARY

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

3.2 The four scheduled meeting dates for the 2018/19 Council year as set out in the draft programme of meetings considered by General Purposes and Licensing Committee on 31st January 2018 are as follows:

4.00pm, Wednesday 11th July 2018
4.00pm, Wednesday 17th October 2018
4.00pm, Wednesday 16th January 2019
4.00pm, Wednesday 3rd April 2019

3.4 The work programme is set out in Appendix 1 below.

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

APPENDIX 1

HEALTH SCRUTINY SUB-COMMITTEE WORK PROGRAMME

16th January 2019
PRUH Improvement Plan – Update from King's Foundation NHS Trust (King's)
Care Coordination Centre Update (Bromley Healthcare)
Integrated Adult Mental Health Strategy (LBB/CCG)
Joint Health Scrutiny Committee Verbal Update (JHOSC Members)
3rd April 2019
PRUH Improvement Plan – Update from King's Foundation NHS Trust (King's)
Joint Health Scrutiny Committee Verbal Update (JHOSC Members)
Not Programmed
Presentation from Debbie Hutchinson, Director of Nursing (PRUH) (King's)
King's Productivity Improvement Programme Update (King's)
Impacted of the Integrated Care Model: Update (King's/CCG/LBB)