NHS
Bromley Clinical Commissioning Group

Integrated Commissioning Plan 2013 - 2016

This document comprises three main sections, dealing individually with Strategic Overview, Programmes for Delivery, and Clinical Leadership and Governance Functions.

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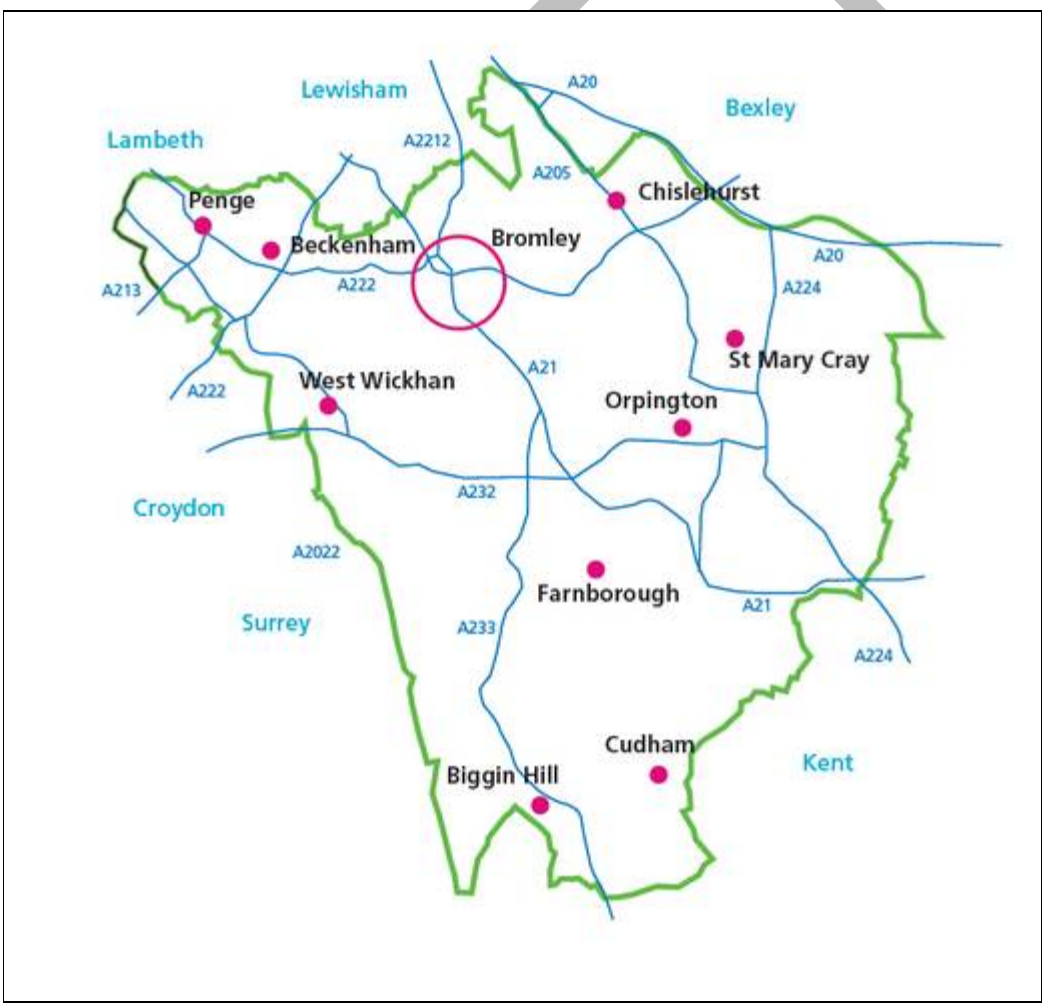

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STRATEGIC OVERVIEW

1.1 Introduction

NHS Bromley Clinical Commissioning Group became a statutory body in April 2013 with membership of 46 general practices serving the residents of the London Borough of Bromley. The combined registered population of Bromley's general practices is 331,465[1]. The CCG is coterminous with the London Borough of Bromley and the former Bromley PCT boundaries.

In order to fulfil its responsibilities, the CCG was authorised in January 2013 as fit for purpose to fulfil its functions as the commissioner for local health services with two conditions, one of which has been subsequently cleared, and one remaining condition pending clearance by April 2013. The remaining condition is requirement for a 'clear and credible plan' and is Red rated at level III. The Governing Body has a Clinical Chair and membership includes six Clinical Leads and has Local Authority and a Patient's representative in attendance. The CCG was formerly operating in shadow form, with full delegation of commissioning budgets, since April 2012.

We build on a strong track record of local clinical commissioning and are able to demonstrate powerful local GP leadership and support, Local Authority engagement and a clear and credible local Quality Innovation Prevention & Productivity (QIPP) plan.

A key factor in the strategic context of the CCG is the financial challenge facing the health economy, and in particular South London Healthcare NHS Trust (SLHT). A Trust Special Administrator (TSA) was appointed in July 2012, with a remit to produce a draft report by the end of October setting out a sustainable configuration for acute services across South East London. Following producing the report and a short period of consultation including input from the CCG, the Secretary of State took a decision in January 2013. The recommendations most affecting the CCG are:

- King's College London to assume operational running of the Princess Royal University Hospital (PRUH)
- Implementation at greater scale and pace of a Community Based Care (CBC) strategy that commissioners across South East London developed collaboratively
- Full utilisation of Beckenham Beacon as a facility for delivery of health services
- Disposal of Orpington Hospital and relocation of services to other local sites
- Development of an inpatient mental health centre at Queen Mary's Hospital, Sidcup

This 3 year Integrated Commissioning Plan for the CCG sets out our vision and strategic objectives for 2013 – 16 built upon the platform of our local needs assessments and delivered through the vehicles of our strategic programmes, underpinned by visionary and transformational clinical leadership and solid governance.

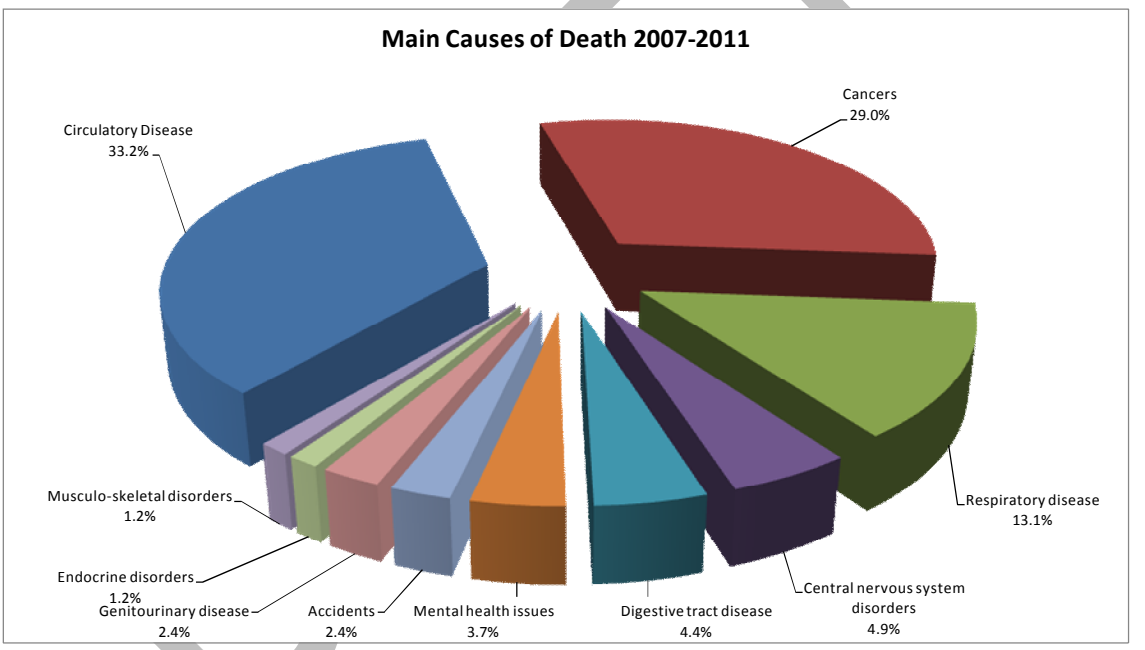
[1] As of 31st December 2012 derived from the Exeter system

1.2 Bromley the Place - Joint Strategic Needs Assessment

The 2012 Joint Strategic Needs Assessment (JSNA), written in partnership with London Borough of Bromley, sets out a framework of key health and socio-economic factors which drives our planning activities so that we can focus our resources. As part of the development of local services for Orpington, we also commissioned a separate strategic needs assessment focused on the needs of Orpington.

The JSNA for Bromley describes in detail the priority health issues which we must address as a health and social care economy to prevent the worsening of ill health and the burden of disease across the borough. The key causes of death in Bromley are circulatory disease, cancer and respiratory disease, driven by a variety of factors such as obesity, unhealthy lifestyle, and poor housing. Figure 1 sets out the main causes of death in the period from 2007-2011:

Figure 1: Main Causes of Death 2007 - 2011



The number of older people as a proportion of the population of Bromley is expected to remain fairly stable over the next 10 years at 15.6%. However, Bromley already has the largest ageing population in London. The implication of this large demographic group is the increased demand for social care services from people who want to stay at home and are living at home longer. As people's needs become more complex support packages will become increasingly expensive to deliver and will put pressure on already constrained budgets.

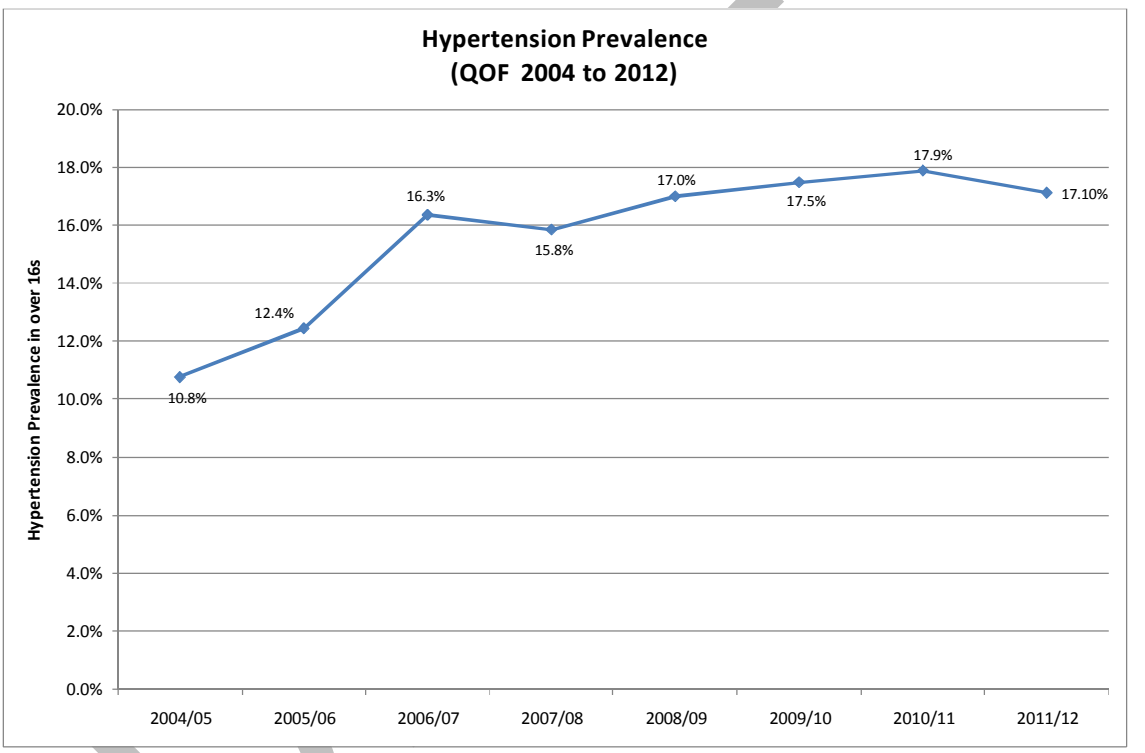
Bromley has also seen a mini baby boom in recent years with a rise in births by 29.1% since 2002. As a result, there is now a much greater number of 0-4 year olds. This upward trend in birth rate is expected to remain over the coming few years.

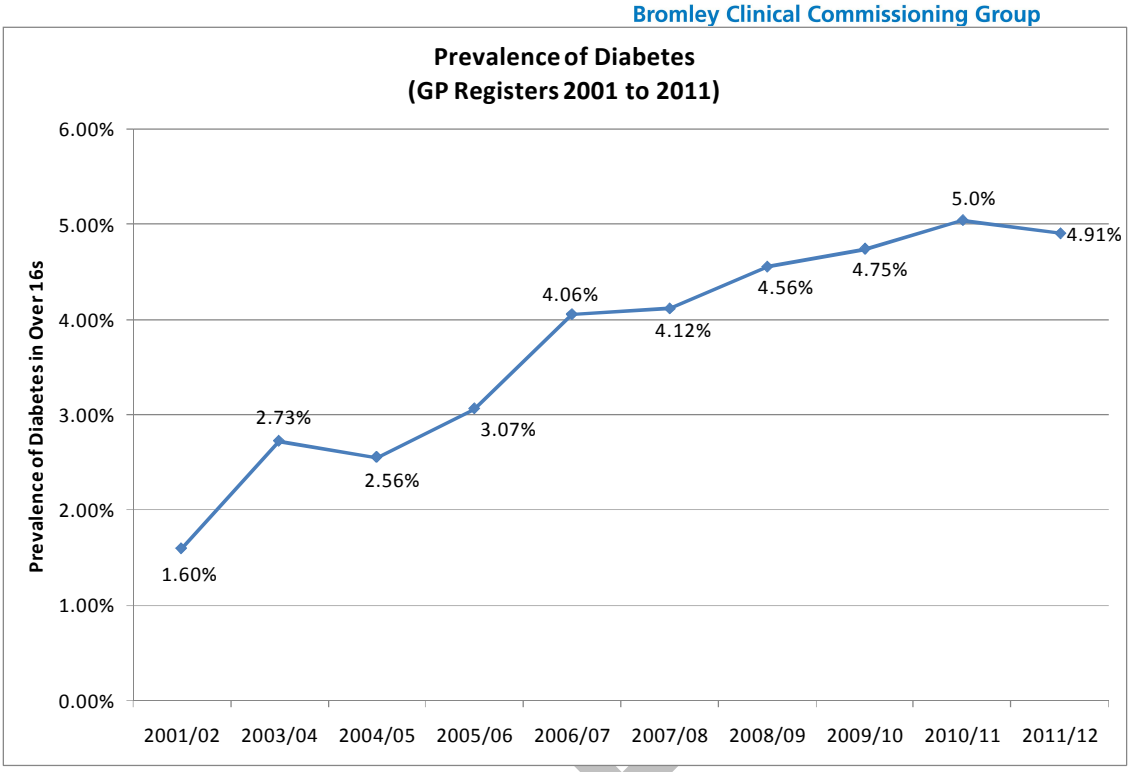
Likewise there has been a significant increase in the proportion of minority ethnic population now comprising 22.6% or more than 1 in 5 residents in the 2011 Census.

The prevalence of diabetes has increased in Bromley from 1.6% to 5% over an 8 year period. The increase in prevalence is significant because diabetes is classed as a vascular disease which is often a precursor to heart disease or stroke. The Impact Diabetes Report in the Journal of Diabetic Medicine, April 2012 estimates that NHS-wide a total of 80% of the current spend on diabetic-related complications could be saved through better management and prevention of the disease. It is reported that by 2035, 17% of the total NHS spend will be on diabetes alone.

Figure 2 below sets out the growing prevalence of hypertension and diabetes in Bromley in recent years:

Figure 2: Prevalence of hypertension and diabetes





Smoking is a major risk factor for circulatory disease, cancer and respiratory disease. Smoking prevalence in Bromley is estimated to be 18.1% (2011-12) in people aged 18 years and over, as compared with 20.0% for England. Smoking prevalence in Bromley has been rising since 2009 and is now ranked as the thirteenth lowest smoking prevalence in London; this is a worsening position. Smoking prevalence in routine and manual occupational groups in Bromley is higher than in the general population at 24.3% (2011-12).

Obesity is a key risk factor for circulatory disease and cancer, and also for diabetes which is a precursor to circulatory disease. Obesity has an attributable risk for Type 2 diabetes of 24%. Therefore, any changes in the prevalence of obesity will have a significant impact on the prevalence of diabetes. Data collected for Bromley as part of the National Child Measurement Programme show rising trends in the prevalence of obesity and overweight in children in reception year and year 6. Prevalence of overweight children in reception was 12.9% and in year 6 was 14.5%. For obesity, the figures were 7.8% for reception and 16.4% in year 6.

The incidence of sexually transmitted infections in Bromley is generally lower than in London or in England, but HIV prevalence in Bromley has been rising over the last few years and is becoming more widely distributed across the northwest of the borough.

The teenage pregnancy rate is lower in Bromley than for London or for England. The ONS reported figures for 2010 show Bromley as having a conception rate of 26.4 pregnancies per 1000 females aged 15-17. The teenage pregnancy rates have decreased in Bromley by 17.8% since 1998. Adverse health issues for teenage mothers as compared to older ones include increased infant mortality, premature delivery, more emergency admissions, and poor maternal emotional health and well-being.

The number of people on the Mental Health register has been rising. People with

mental health problems not only present with social problems but also have increased risk of physical ill health. The prevalence of recorded dementia has remained constant since 2006. A local care pathway, building on the national guidelines, and created by a broad spectrum of stakeholders, has been in place since 2010. A needs assessment for dementia was carried out last year which included an assessment of care provided in Bromley against the NICE Quality Standards.

The local alcohol profile 2011 for Bromley shows that alcohol attributable mortality in males and females is lower than the national and London averages, and is lower than last year. Although recent research evidence suggests that alcohol misuse is a problem in people aged 65 years and over, there is no routine data collection or screening for alcohol problems in this group.

The estimated number of problem drug users is 4,672. At present the first point of treatment for substance misuse is provided by an open access service, REACH which is part of Bromley Community Drugs Project. Over 60% of people in treatment are between the ages of 30-49.

1.3 The Bromley Health and Wellbeing Strategy

The World Health Organisation (WHO) defines health as *"a state of social, physical and mental well being and not merely the absence of disease."* UK government policy is now focusing on health in this wider, more holistic way, making it clear that improving health is everyone's responsibility. Emphasis is on the prevention of illness rather than just the treatment of disease.

This takes health beyond the realm of the NHS and into the community. There is increasing emphasis on the need for partnerships, a shared health vision / agenda, as well as a specific leadership role for local government and for people to engage with their own health.

The Bromley Health and Wellbeing Strategy has been jointly developed by Public Health consultants, local authority agents, GPs, NHS representatives, local health and voluntary organisations. The strategy details how the Bromley Health and Wellbeing Board intends to work with cross-sector partners, including local residents, voluntary organisations and community groups, to reduce health inequalities and improve the health and wellbeing outcomes of our local communities and workforces.

The Bromley Health and Wellbeing Strategy 2012 – 2015 describes its strategic vision as:

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

It states that this will be achieved by improving the quality of life and wellbeing for the whole population of Bromley, and for those with specific health needs, leading to an increase in life expectancy in the targeted areas.

It describes nine priorities to be targeted by health and local authority commissioners in partnership, and these are:

- Diabetes
- Hypertension
- Dementia
- Support for carers
- Children referred to Social Care
- Obesity
- Anxiety and Depression
- Children with Mental and Emotional Health Problems
- Children with Complex Needs and Disabilities

These priorities have been determined through a process of consultation with partnership groups across the entire health and social care economy in Bromley, looking at health outcomes supported by local and national data to determine importance and impact and where we need to focus our resource.

2.2.1 Key themes from the Health and Wellbeing Strategy

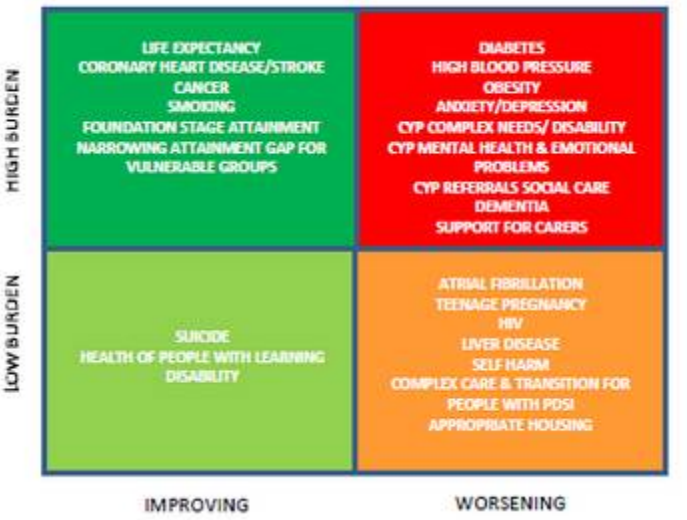
The key themes and priorities to improving health in Bromley have been identified using the 2012 Joint Strategic Needs Assessment, which provides detailed analysis of trends and issues impacting on health. This process has highlighted areas that need to be addressed in order to make progress in tackling some of the most pressing issues facing residents today.

In order to decide where best to focus joint health and local authority efforts to

improve the health of the population it is helpful to use a prioritisation framework. A simple way of considering the relative priority of different health issues is to consider the burden in terms of the numbers of people affected, and then whether the problem is improving or worsening over time. The highest priority is allocated to the issues creating the highest burden which seem to be worsening over time.

Figure 3 below has been populated to show the relative priorities of the key issues. The red box represents the highest priority issues, according to this framework, which the Health and Wellbeing Board have identified as shared priorities.

Figure 3: Health and Wellbeing Board Priority Setting

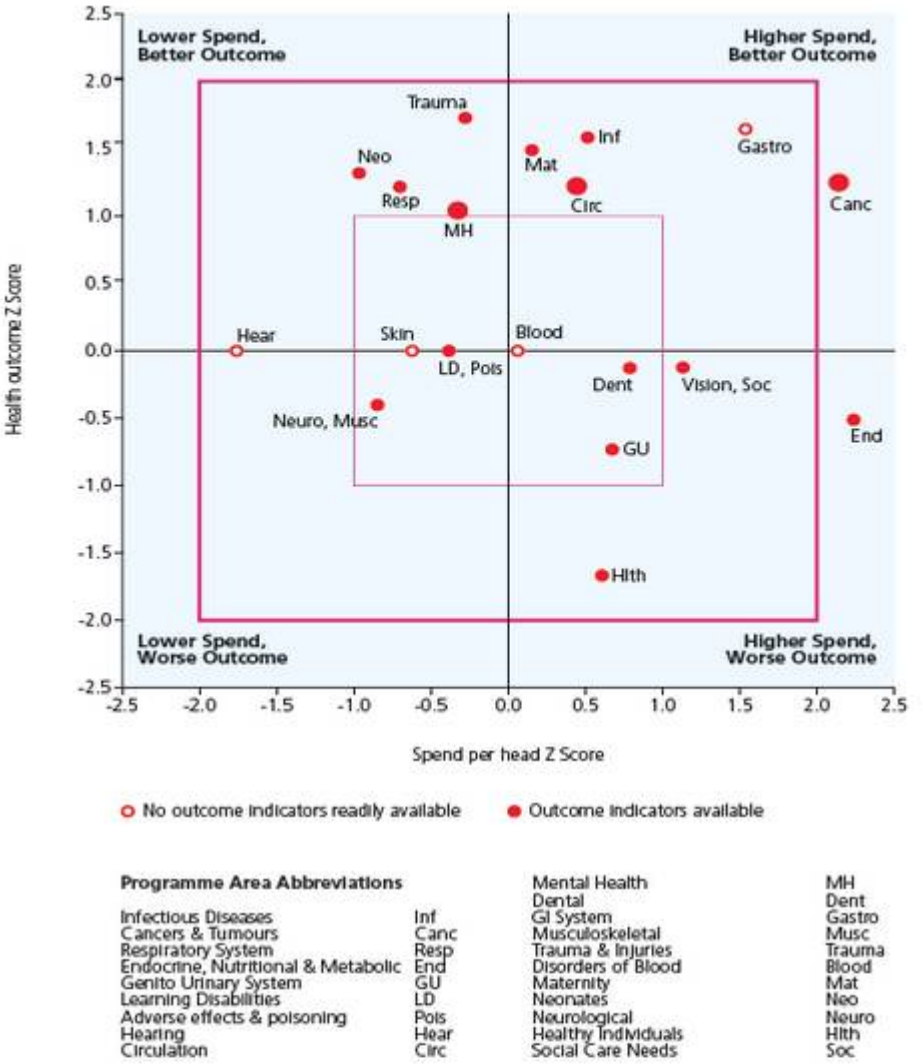


1.4 Priority Health Outcomes

Using programme budgeting tools, such as the Spend and Outcomes Tool, it is possible to more accurately target resources to areas where our health outcomes need to be improved.

Figure 4 below shows a quadrant spend and outcomes analysis for the previous Bromley PCT patient population area, relative to other England PCTs. Using the most recent data available from 2010/11 this demonstrates that on the whole we are achieving good or acceptable outcomes for most of our key programme areas.

Fig 4: Spend and Outcomes Analysis



Two programmes fall outside the expected range. For Cancer it can be seen that our spend is comparatively high, and our outcomes are also better than expected. Since 2008-09 Bromley spend has increased and outcomes have improved. Even though Cancer remains the second highest cause of death in Bromley, this suggests that Cancer should not be a focus for our

investment in the short to medium term. On the other hand, the Diabetes related programmes (Endocrinology, Nutritional and Metabolic) have a high spend, but worse than expected outcomes. This suggests that we should focus on this group of services, to reshape our investment and secure more effective outcomes.

In addition to the health outcomes identified above through the local needs assessments, the CCG has prioritised three further local measures of success for 2013-14. The National Operating Framework for 2013-14 provided CCGs with a support pack of data that set out areas where Bromley was performing less well historically than other CCGs with comparative demographics. Bromley is clustered in the Thriving London Periphery for the purposes of the Office of National Statistics with demographic characteristics similar to those in Sutton, Richmond, Hillingdon, and parts of Berkshire. The CCG engaged with its GP practice membership and the Local Authority to select its three local priorities via a formal process which was then considered by the Strategic Planning Group and Clinical Executive. The three measures that have been prioritised are:

- Patients feeling supported to manage their own condition
- Patient reported outcome measures for elective procedures – knee replacement
- Emergency readmissions within 30 days of discharge from hospital

1.5 Financial Overview

The CCG inherits a strong financial track record from Bromley PCT and achieved its planned surplus of £5.2m in 2012/13. In doing so, we were able to provide non recurring support to other parts of the local health economy, and to identify a joint resource for the development of integrated care services under a Section 256 agreement with London Borough of Bromley. However, this relatively sound position sits within the context of an unsustainable position across the health economy. Although we have many challenges to face in the coming years, Bromley CCG, with its member practices, has the will, capability and skills to transform health services and improve health for Bromley.

South London Healthcare NHS Trust

Bromley's main acute provider **South London Healthcare NHS Trust** (SLHT) was severely financially challenged, with a deficit of £68m in 2011-12. Financial recovery was impeded by poor financial and information systems, and difficulty in systematically engaging clinicians in shaping the organisation to reflect the external pressures in faces. Bromley was one of three main commissioners, and worked closely with Bexley and Greenwich to develop and manage contracts with SLHT.

In July 2012 the Secretary of State exercised his powers under the Unsustainable Provider Regime, to appoint a Trust Special Administrator (Matthew Kershaw) to act in the place of the Board of SLHT. This action was taken following a number of attempts to support the Trust in financial terms, to ensure the sustained viability, quality and safety of services to patients in outer SE London. The Trust Special Administrator subsequently provided a draft report to the Secretary of State on recommendations for the reconfiguration of local acute services in October, and following a consultation period including input from the CCG, a ministerial decision was taken in January 2013.

The recommendations most affecting the CCG are:

- King's College London to assume operational running of the Princess Royal University Hospital (PRUH)
- Withdrawal of SLHT services from Beckenham Beacon and maximisation of this facility by the CCG through commissioning and re-procurement
- Relocation of services currently delivered from Orpington Hospital to other local sites
- Implementation of the Community Based Care (CBC) strategy that commissioners across South East London developed collaboratively

Through this difficult period, the focus for clinical commissioners will focus on ensuring the maintenance of clinical quality and patient safety as services adapt within a framework of financial constraint. This will be a challenging process. However, clinical commissioners also view this as an opportunity to cut through some of the existing systemic constraints, to accelerate the reshaping of services across the local health economy.

The reconfiguration agenda for acute services is now central to the CCG's strategy.

Other Local Healthcare Providers

In addition to South London Healthcare NHS Trust, Bromley CCG commissions services from a number of key providers, as follows:

- Bromley also receives acute services from **Lewisham Healthcare (£9m)**, for emergency services for patients to the north west of the Borough, specialist paediatric centre and elective referral through choice. Lewisham Healthcare is due to merge with Queen Elizabeth Hospital, Woolwich as part of the SLHT Trust Special Administrator recommendations, and changes are planned to the emergency receiving capacity.
- Tertiary services and secondary services are also provided by **Kings Healthcare Foundation Trust (£29m)** and **Guys and St Thomas's Foundation Trust (£33m)**. Tertiary services cover cancer, renal and cardiac services, and secondary care services are accessed by GPs in the north of the borough. The value of contracts with both providers is increasing, in part to reflect a growing choice for elective secondary referral, and in part to reflect increasing prices for non PBR activity. Both trusts are facing financial and performance pressure as a result of the flow of patient activity from secondary to community/primary care, and the movement of tertiary services to secondary care hospital settings. The two foundation trusts have agreed an outline business case for the formation of a single integrated provider with South London and Maudsley NHS Foundation Trust. The CCG anticipates that the relationship with Kings Healthcare will change as the Foundation Trust acquires Princess Royal University Hospital, under the TSA recommendations.
- Specialist services are managed across London, with risk share agreements to spread the financial consequence of low volume, high cost activity. Over the next two years there will be a significant increase in the range of activity defined as specialist services, and the transfer of contracts from existing secondary care contracts to specialist contracts is already posing financial risks and uncertainty.
- The main mental health provider is **Oxleas NHS Foundation Trust (£35m)**. There is a significant dialogue with the trust about the movement of activity from Tier 4 to Tier 3, and from Tier 3 to Tier 2, bringing patient activity closer to community and primary care services. This includes changes in the way that services are provided for children and adolescents. There is also an increasing dialogue with the trust about the role that mental health services have to play in relation to managing the interface with secondary care, to ensure that patients with dementia can be managed at home, or in the community as an alternative to acute hospital admission. Under the TSA recommendations inpatient mental health services will transfer from Green Parks House at Princess Royal University Hospital, to the Queen Mary's Hospital site.
- Specialist mental health services are also provided by **South London and Maudsley NHS Foundation Trust**. In addition Bromley commissions a range of services for drug and alcohol misuse from local specialist providers, in partnership with the London Borough of Bromley.
- Community services are largely provided by **Bromley Healthcare** which is a Social Enterprise company set up on April 2011 through the transfer of the community provider services from Bromley PCT. As an emerging organisation Bromley Healthcare is still establishing its client base beyond Bromley, and its strategic intent, but it will play a significant part in the development of integrated care services and opportunities to bring patient activity closer to community and primary care centres.
- Responsibility for Learning disability services is in the final stages of transfer to the London Borough of Bromley, and this will enable the disposal of the Bassetts site, which includes both the Resource Centre and the CCG headquarters building. The London Borough of Bromley is the lead agency for all LD services in the Borough including NHS Bromley's

residential services for around 90 LD clients. While the London Borough of Bromley already manages NHS Bromley's residential service under a section 75 agreement, the service is still fully funded by NHS Bromley.

Primary Care Providers

The CCG recognises the importance of its role in improving the performance of primary care providers, in support of the clinical commissioning process. Although the primary contractual relationship will be between GPs, community pharmacists, dentists and opticians and the NHS Commissioning Board, the CCG will work with the local office of the NHSCB to ensure that quality is maintained and that the CCG's ambition for continuous quality improvement is reflected in the performance management of primary care. This will be through an initial project in 2013-14 to analyse the current state of the primary care landscape and to develop and agree a future model to support the CCG's vision for primary care. The CCG will also work with general practice as members of the commissioning group to ensure meaningful engagement in the commissioning agenda.

The current profile of incentives for primary care is largely historic, and will benefit from a full review in the context of the CCGs Strategic Objectives which the CCG plans to undertake during 2013-14, so that an overarching Primary Care Improvement Plan can be developed using historical funding in new ways.

1.6 Vision and Goals

Vision

Clinical commissioners have a unique role within the NHS, providing an individual patient perspective to shape the commissioning and delivery of healthcare. Working from the starting point of the health and social care needs of our population in Bromley, as described by our Joint Strategic Needs Assessment, and our assessment of the current state of the local health economy, our Vision has been defined as follows:

Better Health: improve health outcomes and reduce health inequalities across Bromley.
Better Care: transform the landscape of healthcare, by developing partnerships, leading to an integrated healthcare system with improved access and quality.
Better Value: create a sustainable health economy reinforced through collaborative working.

Strategic Goals

From the vision set out above we have identified four Strategic Goals. These paint a more detailed picture of the changes that we expect to achieve by the end of the three year period of this Integrated Plan. They start to define the Vision in more detail, and form the basis for developing more measurable definitions of our strategic intent:

Goal 1: Better Health
Identify and develop programmes to reduce the level of health inequalities in the more deprived areas of Bromley.
To identify and develop programmes which will systematically demonstrate improvements in key health outcomes.
To ensure that patients, service users and their carers are at the centre of all decisions we take around their healthcare, are encouraged to understand and manage their own condition and have a positive experience of care.
Reduce health inequalities by encouraging people to adopt a healthier lifestyle through a programme of education and targeted interventions known to work to increase the control individuals have over their own health and wellbeing.

Goal 2: Better Care
Improve access to and extend choice of services and patients, service users and their carers, ensuring that clinical pathways are fit for purpose and that the services we commission meet the highest possible quality standards, whist increasing the pace of delivery of the quality, innovation, productivity and prevention (QIPP) challenge.
Empower those people in Bromley with long term conditions, particularly older people, to exercise control over their own lives and prevent problems arising or worsening and enabling them to independently manage their own health and well being, thus improving their health, outcomes and preventing them dying prematurely. To strengthen and fully integrate the infrastructure supporting this cohort of people ensuring that their health needs are met 24/7 in a planned and structured way

Goal 3: Better Value
To work with South London Healthcare NHS Trust and other local healthcare providers and stakeholders to develop and implement a clear and sustainable plan to manage the underlying financial position of the local health economy.

To facilitate the reshaping of provider facilities and resources to reflect the relocation of services closer to patients and their homes, and to encourage integrated services.
To ensure that quality and performance of services remain paramount through this process of change.
To create and maintain a sound business framework for the development of local healthcare services through clinical commissioning.
To undertake a process of education and reform to ensure our provider workforce has the necessary skills to deliver new and challenging pathways of care.

1.7 Strategic Objectives

From the broad Strategic Goals set out above we have identified a range of Strategic Objectives which will test whether or not we deliver our Strategic Goals over the next three years. They are designed to be measurable, so that we can demonstrate progress during the life of the Integrated Plan, and start to set some priorities in terms of the pace of achievement. Table 1 below sets out the Strategic Objectives, the Strategic Goals they link to, a broad indication of the timescales and how we will measure progress.

Table 1: Strategic Objectives 2012-15

Ref	Description	Goals	Measures	
1	Improve the health and care given to elderly and vulnerable adults in Bromley by implementing integrated care pathways	Better Care Better Health	Emergency hospital admissions for 65 years and over	
2	Address the burden of disease caused by reducing the prevalence of the disease and reducing longer term complications by earlier detection and better management	Better Care Better Health	Obesity, diabetes, COPD prevalence Unplanned admissions with a primary diagnosis of obesity, diabetes or COPD	
3	Improve outcomes for patients diagnosed with cardiovascular disease, by maximising management of diagnosis and treatment of patients with medically manageable conditions	Better Care Better Health	CHD mortality <75 from 55 to 54 per 100,000 Unplanned admissions with a primary diagnosis of CHD Review of CHD mortality rates - annual	
4	Improve outcomes for patients diagnosed with respiratory disease	Better Care Better Health	Unplanned admissions with a primary diagnosis of respiratory disease	
5	Improve outcomes for patients diagnosed with mental health problems, including dementia	Better Care Better Health	IAPT – increase the proportion of people referred for psychological therapy (6% to 15% over the next 2 years) Dementia Find, Assess, Investigate, Refer (FAIR) CQUIN	
6	Improve the safety of maternity services	Better Care	Dashboard of maternity and perinatal indicators	
7	Reduce health inequalities across the Bromley borough by working in partnership with LBB and others, including patients and service users by promoting self care / management of their condition.	Better Care Better Health	Differential best to worst wards Patients in self care schemes	
8	Improve patient experience by seeking their feedback and engagement on a range of issues	Better Care	Ensuring patient satisfaction surveys / questionnaires are acted upon and evaluated year	

			on year	
9	Develop pathways to facilitate the achievement of A+E 4 hour wait targets	Better Care Better Valu	4 hour wait (95%) at Princess Royal University Hospital	
10	Develop care pathways to facilitate achievement of RTT 18 week target for admitted and non admitted patients	Better Care Better Value	Admitted RTT 18 weeks (90%) Non admitted RTT 18 weeks (95%)	
11	Achieve financial balance through judicious budgetary control and an innovative approach to commissioning	Better Value	Achievement of planned surplus	
12	Design a sustainable set of services to serve Orpington residents within the framework of overall affordability for Bromley residents.	Better Care Better Value	Monitor progress of Orpington project – key milestones Cost of new Orpington site services	
13	Develop our people through leadership, training and investment to ensure they have the capability to commission effectively	Better Value	Number of staff with annual appraisal and PDP	
14	Support provider participation in research and development of new pathways of care	Better Care Better Value	Value of CQUINs for provider involvement in new pathways	
15	Promote joint working with London Borough of Bromley to maximise potential from joint resources	Better Care Better Value	Value of services managed jointly	
16	Seek engagement with partner commissioners and provider organisations to maximise potential from joint resources	Better Care Better Value	Value of jointly commissioned and integrated procured schemes	
17	Develop the Care Closer to Home agenda to maximise productivity in care pathways	Better Care Better Value	Value of schemes providing services in a non acute setting	
18	End of Life Care	Better Care Better Value	% of deaths that occur at preferred place of choice (recorded in Advanced Care Plans)	
19	Quality of services	Better Care	Dashboard of quality indicators to be developed	

1.8 Development of Services for Orpington – Strategy in Practice

Strategy in Practice:
Review of health services in Orpington.

Background

In 2010 local services across Bromley, Bexley, Greenwich, Lewisham and parts of Southwark were re-organised following a public consultation – "A Picture of Health". This envisaged the centralisation of elective surgery to Queen Mary's Hospital, Sidcup and no future role for surgery at Orpington Hospital. As a result, surgery facilities at Orpington Hospital were closed. Following on from this reorganisation we assessed the health needs of the Orpington population, which include an ageing population, health concerns such as obesity, heart conditions, high blood pressure, diabetes, and COPD. We identified a need for better health education to enable our population to make healthier choices with respect to their lifestyle. We have identified a number of improvements to enhance patient care, such as increasing community health services to prevent ill health, improving accessibility to GP practices and enhancing care for patients with complex conditions. Orpington Hospital is relatively expensive to run and there are constraints to the provision of modern healthcare services. So, our proposals aimed to save £2M per year by reviewing the use of Orpington Hospital, as well as ensuring the maintenance of high quality standards for local patients.

How we engaged with our local population

Our engagement process with our strategic partners began in October 2011, and the feedback has formed the cornerstone of our current consultation document "Improving Health Services in Orpington". This public consultation will run from July – October 2012, and with full stakeholder involvement, including critically how we use hospital services delivered by South London Hospitals Trust (SLHT), we are seeking local feedback on the proposals contained within the document. The local population fed back in a number of ways - by means of a questionnaire contained within the consultation document, at Public meetings and at a range of drop in sessions arranged across the Borough.

What we proposed

Our proposals described delivery of a full range of modern health care services aimed at improving access, promoting healthy living and provision of better premises for 3 outdated GP practices. Specialist outpatient services will move to hospital premises, and our preferred option for local delivery includes convenient support groups for patients with long term conditions, flexible space for a range of community services and for all GP practices. It also provides easy access to health tests and advice services for our patients. We have already increased support for wellbeing across the whole of Bromley borough, with vascular risk assessment and management, support for people to stop smoking, obesity management for adults and children and management of high blood pressure. Our current proposals for Orpington will boost this approach and focus on the specific needs of our local population.

The option that has been agreed at the Governing Body public meeting on 29th November 2012 following consultation is:

- **A new Community Health and Wellbeing Centre**
  This option offers a comprehensive range of services and an integrated approach to many healthcare needs, including diabetes and COPD clinics, phlebotomy, radiology and ultrasound, space for local GP practices and clinics supporting LTC management, contraceptive services, elderly care outpatients, voluntary / community advice services, and physiotherapy. This effectively will create a "one stop" experience for patients who can access all of their local services under one roof.

With this option we are also proposing to meet local health needs further by moving hospital outpatient clinics from Orpington Hospital to the Princess Royal University Hospital (PRUH) or moving some to Queen Mary's Sidcup (QMS) and Beckenham Beacon, creating a specialist dermatology service at QMS, moving hydrotherapy to a more suitable site and delivering more intermediate care in the community, reducing the number of IC beds from 62 to 42. Amongst the recommendations in January 2013 from the Trust Special Administrator for South London Healthcare NHS Trust, this option was preferred although our actions during the design and implementation phases may need to be coordinated with wider proposals for the service configuration across South East London.

In drawing up our proposals we considered fully the use of the current Orpington Hospital facility, which is getting older and is not up to modern clinical standards, and have concluded that continued use of this facility is an inefficient use of NHS money. We believe our proposals are the best-fit for our community in that they will provide a new style of local health services with a focus on preventing ill-health, improve care for patients with complex conditions in centres of excellence and will improve buildings for 3 local GP practices that lack space and are not accessible to people with disabilities. Both our proposals offer local people all of the essential health services needed. However, the **Community Health and Wellbeing Centre** aims to bring many more out of hospital services together under one roof. This will give our population a greater degree of accessibility to a wide range of services, will act as a "drop in centre" to pick up advice and perhaps join a healthy living session.

Next steps:

Following the recommendation from the TSA in January 2013, the work to redesign services to fully utilise a new Community Health and Wellbeing Centre sited in Orpington will be taken forward as a key part of our Planned Care Strategic programme of work over the next three years to 2016. Services are to be vacated from Orpington Hospital and moved to new sites by September 2013. Redesign of care pathways and locating of services at the new Orpington facility will take into account their fit with Commissioning priorities, clinical and patient benefits, affordability and the ability to adapt to future changes.

PART B
PROGRAMMES FOR DELIVERY

2.0 Approach to Planning and Delivery

The previous section identified the 17 Strategic Objectives which arise from our review of the unique Strategic Context in which we find ourselves, and the development of our overarching Strategic Goals. We plan to deliver our Strategic Objectives through the measurable achievement of our six strategic programmes over a three year period or longer.

In order to deliver the schemes that will drive us towards the achievement of these Strategic Objectives we recognise that we need to organise ourselves in a way which coordinates the resources and opportunities available, and creates synergies between specific schemes. This helps us to move from a wider Strategic Objective framework to specific schemes and key initiatives that can be measured against key deliverables.

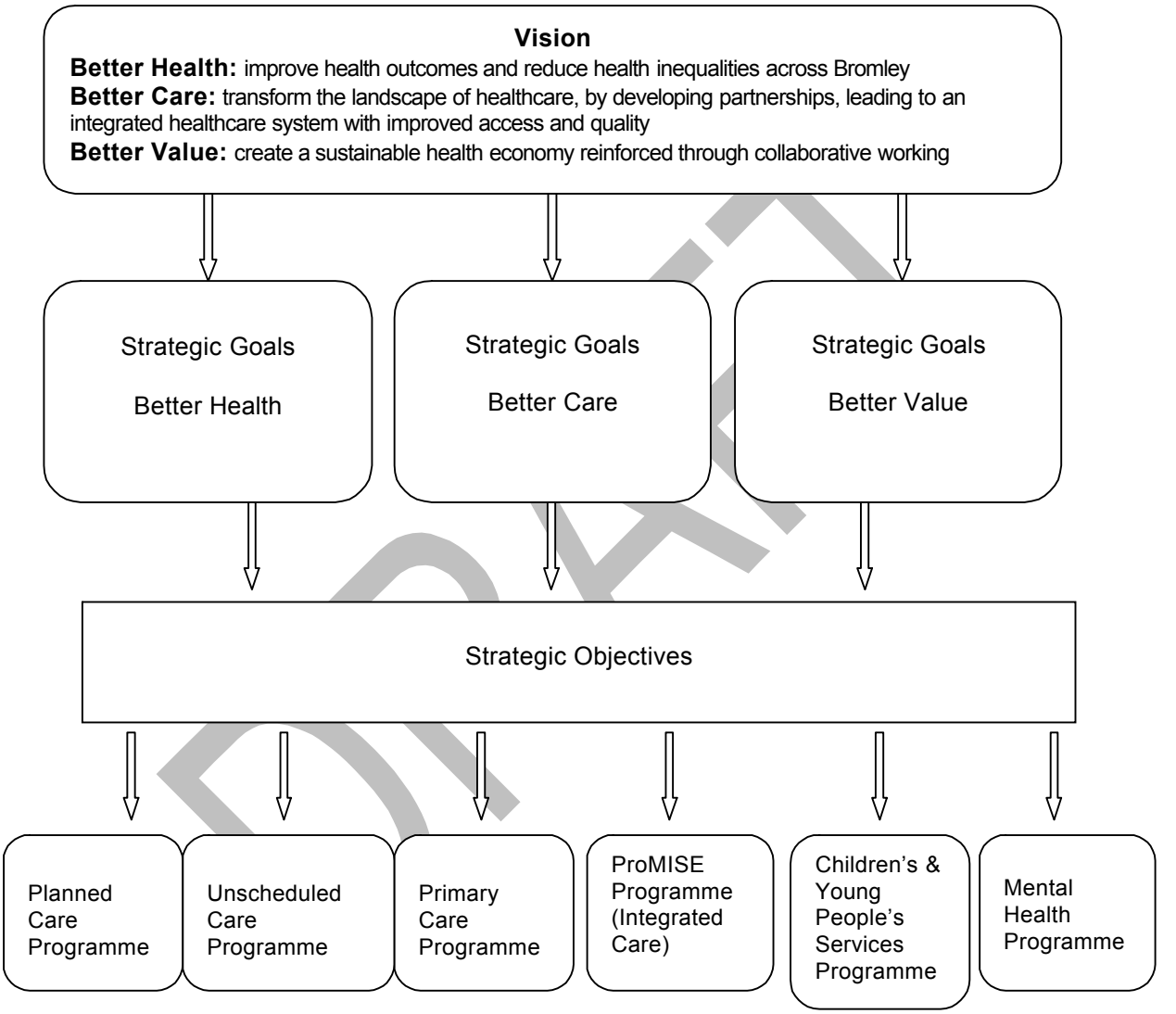
During the transition period from PCT to CCG our approach to managing the implementation of service plans and QIPP in partnership with our colleagues at SEL Cluster required us to simultaneously maintain a focus on delivery while also strengthening the role of Bromley Clinical Commissioning to take ownership and responsibility of all our plans during 2012/13. We now have robust programme management mechanisms in place to ensure that we can bring the benefits of strengthened clinical leadership to the local health and social care system.

Working with our GP colleagues, partner commissioners and providers, we have mapped out and assessed the challenges facing the Bromley Health and Social Care economy and the priorities which need to be addressed, to deliver sustainable health services. We have a shared ambition with our partners at London Borough of Bromley which is being progressed through an integrated approach to commissioning, and supported by our Health and Wellbeing Board. As we progress our commissioning strategy with the local health economy, some of the key areas we will be focussing our attention on in the medium term include:

- Working with our partners across the health economy to implement the recommendations of the TSA report
- Ensuring the right landscape of services – right care in the right setting and reducing reliance on acute services
- Reducing health inequalities and improving health in Bromley
- Ensuring that primary and community services are equipped and able to deliver health care outside of hospital
- Developing clinical commissioning by engaging more widely and deeply

2.1 Strategic Programmes - Overview

From the Strategic Vision, Goals and Objectives set out above the CCG has developed six focused and cohesive Strategic Programmes which ensure that the appropriate links with key stakeholders can be maintained across schemes within each programme, as set out below:



Bromley Clinical Commissioning Group

BROMLEY

2.2 PLANNED CARE STRATEGIC PROGRAMME

2013-16

1. Profile

Planned Care is one of Bromley Clinical Commissioning Group's six strategic programmes identified through the Integrated Plan 2012-15. It focuses on redesigning specific whole systems care pathways within given resources to ensure good quality care is provided in the right setting by the right person at the right time.

Definition: Planned care means the delivery of health services (assessment, diagnosis and treatment) requiring clinical intervention, where there is a pre-arranged appointment and is not considered to need urgent or emergency care. Although cancer has not been identified as one of the CCG's strategic priorities due to high expenditure and positive outcomes as identified through programme budgeting, it is recognised as a long term condition and an important clinical area and therefore it is included in the Planned Care programme. Likewise, maternity services are included here to ensure that changes to the national acute contract for this specialty are proactively monitored through the governance arrangements of the Planned Care programme. Planned care can be offered by a variety of practitioners, in a variety of settings, including GP practices, community clinics, district general hospitals or specialist tertiary services.

Profile of Current Service: The forecast spend for planned care 2012-13 is in excess of £104 million (£47.7m for outpatient services and £56.6m for inpatient services). This figure excludes all associated non Payment by Results activity e.g. diagnostics, pathology, surgical appliances etc. The top ten specialities (by spend) are shown in the tables below.
The CCG commissions planned care activity from a range of NHS and Non NHS providers for Bromley residents. The main provider of care is South London Healthcare Trust, delivered through Princess Royal University Hospital.

Programme Budget Forecast Outturn 2012-13

Elective Inpatient Activity

SPECIALTY	Activity	Expenditure 000's
TRAUMA & ORTHOPAEDICS	3,595	£11,048
GENERAL SURGERY	7,518	£8,585
GYNAECOLOGY	4,217	£4,033
UROLOGY	4,148	£3,553
OPHTHALMOLOGY	3,370	£2,725
ENT	2,102	£2,509
CLINICAL HAEMATOLOGY	3,838	£2,132
CARDIOLOGY	1,337	£2,093
GASTROENTEROLOGY	3,006	£1,767
INTERVENTIONAL RADIOLOGY	1,304	£1,511
ALL OTHER SPECIALTIES	15,233	£16,615
GRAND TOTAL	**49,668**	**£56,571**

Outpatient Activity

SPECIALTY	Activity	Expenditure 000's
TRAUMA & ORTHOPAEDICS	35,582	£4,483
OPHTHALMOLOGY	35,920	£4,354
CARDIOLOGY	15,409	£2,719
GENERAL SURGERY	17,537	£2,695
UROLOGY	14,839	£2,517
DERMATOLOGY	18,302	£2,425
GYNAECOLOGY	16,900	£2,349
PAEDIATRICS	8,765	£1,989
OBSTETRICS	21,994	£1,897
ENT	12,476	£1,402
ALL OTHER SPECIALTIES	231,853	£20,907
GRAND TOTAL	**429,577**	**£47,737**

Source: CSU Data Warehouse as at 14/03/2013

The outturn table above does not include emergency department or urgent care centre attendances, or unplanned admissions that are likely to be affected by a number of the pathway and service redesign schemes described in this programme.

The Trust Special Administrator (TSA), in his January 2013 report, made a number of recommendations that will dramatically affect how health services are delivered in Bromley in the coming years. The recommendations that the CCG aims to deliver through the Planned Care programme are:

- Implementation of the South East London Community Based Care Strategy at scale and pace
- Full utilisation of Beckenham Beacon as a facility for the delivery of health services
- Development of a Health and Wellbeing Centre in Orpington delivering a wide range of health services
- Development of an inpatient major elective surgery centre at Lewisham Hospital

The CCG anticipates reducing significantly it's spend on hospital based planned care activity over the next three years through implementation of the Planned Care programme.

This shift and re-profiling of the way that planned care is provided will change the current health landscape, transforming the face of primary care, community and hospital services. The CCG will need to work with providers, patients, the wider public and many other key stakeholders to transform services in a way that is safe, effective, accessible and equitable, whilst ensuring high quality provision and outcomes and greater value for money.

Range of Services Currently Listed for Review: Primarily, the services selected for redesign are typically high volume specialties and/or specialties where rates of referral and activity in Bromley are high (unexplained) when compared with London/national rates, or are services where concerns about quality and outcome are apparent and are deemed to be priority areas for development by our clinical commissioning colleagues. Furthermore, the services are those where there is strong evidence that they can be provided safely and effectively in out of hospital settings.

In particular, in maximising the opportunity to develop out of hospital services at the Orpington and Beckenham Beacon sites the CCG will fully exploit this unique window to facilitate change in both service design and mode of delivery of planned care services. The scoping and design phases will engage with patients as users and providers, ranging from general practice and other community providers to social care and secondary service providers with a view to developing models of delivery that will demonstrably take their views into consideration.

2. Health Needs

Findings from Bromley's Joint Strategic Needs Assessment (JSNA) 2012 that have an impact on the Planned Care Strategic Programme are the borough's specific demographic trends and key disease challenges. The key issues to note:

- Older people and people with young children, Bromley's two largest age segments, are higher users of services and are more likely to need regular access to GP practices, hospitals, clinics, pharmacies and other services.

- The recent mini baby boom and continued rise in the number of 0 to 4 year olds in the next few years will affect the usage of health services.

- The northern half of the borough (Penge, Beckenham, and Mottingham) is heavily populated. This increases pressure for services as the population has increased. It is important to keep abreast of these changes as service provision may have to adapt to the needs of new communities.

- The Black and Minority Ethnic population is not consistently distributed across Bromley and certain wards have a higher concentration of ethnic minorities than others. The North West of Bromley has the highest proportion of ethnic minority population. These areas may therefore have higher disease burden due to the increased risk amongst certain BME groups. Bromley has a high concentration of settled Gypsy Travellers, situated in the North East of the borough. Evidence demonstrates a lower life expectancy amongst this group as well as a higher proportion of long term illness. It is imperative that the CCG commissions services that are equally accessible and that meet the health needs of its BME population.

- People with learning disabilities in primary care: there is a need to improve registers and recall as there is a considerable shortfall in the numbers of people identified with learning disability who have had an annual health check.

The Planned Care Programme will ensure that all the work areas identified within the programme consider the key demographics listed above and build them into the planning and redesign of planned care services.

The Key Causes of Mortality and Major Health Issues identified within the JSNA

The key causes of death in Bromley remain:
- Circulatory disease
- Cancer
- Respiratory disease

Implications for the Planned Care Programme are a focus on service redesign initiatives that promote self-care and are based in easily accessible community locations with an emphasis on swift access to diagnosis, advice and treatment, fast tracking to specialist care when indicated and the avoidance of duplication and unnecessary intervention. The emphasis will be upon the proactive case management of patients usually within primary care. The associated Primary Care Programme will be a critical enabler of the successful delivery of the Planned Care Programme through its strategic plans to develop and transform the primary care workforce.

Equally, there are strong dependencies and synergies with the Proactive Management of Integrated Services for the Elderly (ProMISE) Programme which aims to more effectively manage

the complex needs of people in Bromley with one or more long-term conditions. For example: key projects already identified within the Planned Care Programme include:

- Cardiology Redesign (specific services for patients with heart failure, atrial fibrillation and cardiac rehabilitation and swift access to diagnostics),
- Chronic Obstructive Pulmonary Disease Service Redesign (to include proactive case management),
- Dermatology and Gynaecology Redesign (which support improvements in the early detection and diagnosis of cancer, which is now defined as a long-term condition).

3. Strategic Context

Trust Special Administrator Report Securing Sustainable Services 2012: The recommendations are set in the context of the need to move towards a model of healthcare that ensures continued improvement in life expectancy and quality of life while addressing the challenges of an ageing population, the growth in the number people with long term conditions and constrained levels of funding to the NHS.

The scale of change required for services provided in the acute settings, and across the wider health economy, is significant. Specific work includes working up a plan for Beckenham Beacon to further support the delivery of the Community Based Care Strategy and in particular the TSA recommendation that these premises be fully utilised. A second key priority for the Planned Care Programme is the design of care pathways to locate services in the proposed new Community Health and Wellbeing Centre at Orpington, fully making use of this new facility for the benefits of patients. This may include the provision of much planned care, outpatients and diagnostic activity from these sites.

NHS Mandate 2012: The first Mandate between the Government and the NHS Commissioning Board, setting out the ambitions for the health service for the next two years.

The key outcome indicators within the Mandate relevant to the Planned Care Programme include:

- improving standards of care and not just treatment, especially for the elderly
- better diagnosis, treatment and care

High Impact Innovations (NHS Improvement) of the six innovations identified the Planned Care Programme will be most influenced by and have the greatest bearing on achievement of:

1. **International and commercial activity**; International and commercial activity is the High Impact Innovation that calls for the NHS to look at the economic and industrial role it has, both with respect to health and care related industries and the wider economy. The NHS has a lot of power intelligence which can be utilised to support and strengthen the economy without having a negative impact on the quality of care it provides. Indeed, by working with other health and care related industries and with the wider economy it can even improve the quality and value of the care provided. Beyond its core role with respect to the health of the local workforce, the NHS has a major impact on local economies, through:
    - Direct employment - the NHS is often one of the largest employers in any locality
    - Spending on goods and services - some £5 billion a year is spent on non-health supplies
    - Training & education - directly and indirectly the NHS is the largest training organisation in the UK.

2. **Digital First;** Aims to reduce unnecessary face-to-face contact between patients and healthcare professionals by incorporating technology into these interactions. 'Unnecessary' means, for example, attending a hospital or GP appointment to receive a test result that says everything is OK; or a visit to an outpatient clinic or GP surgery for something that could be discussed on the phone or via email or SKYPE. **(90% of all interactions in healthcare are face-to-face and every 1% reduction in face-to-face contact could save up to £200m)**

4. Delivery Table

* Please note that some projects have commenced already

Delivery Table			2013-14				2014-15				2015-16				How Success will be Measured	National Operating Framework National / Local Outcomes Indicators	High Impact Innovations	Project Value £'000 2013-16
Scope: Design: Procure Implement: Review			Q1	Q 2	Q3	Q4	Q1	Q2	Q3	Q 4	Q 1	Q2	Q3	Q 4				
Strategic Objectives	**Planned Care Services**	**Description**																
9,20	Gynaecology*	Review effectiveness of intermediate services & arrange handover to The CCG Contract Management Team	R	R	R	R									Action plan fully implemented Direct access ultrasound GP engagement at 75% Reduction in GP referred OP Contract management handed over	4c, 4.1	CQUIN & Digital 1st	£425

9,20	Dermatology *	Review effectiveness of intermediate services & arrange handover to THE CCG Contract Management Team	R	R	R	R								Action plan fully implemented GP engagement at 75% Reduction in GP referred OP Contract management handed over	4c, 4.1			£363
			R	R	R	R												
9,20	Anticoagulation	Re-procurement of current service	I	R										Patient repatriated into local service Costs avoided	4.1, 2.1	Commercial activity		£775
2,3,8,20	Cardiology Redesign	Development of Intermediate based service												GP direct access diagnostics GP direct access to consultant advice Reduction in GP referred OP	4b,c	Commercial activity		£662
			P	P	I	R									1.1, 2.1			
2,3,8,20	Cardiology Contracting	Avoidance of cross-provider multiple admissions	S	D	I	R								Reduction in unplanned cardiology admissions				£722

9,11,20	Musculo Skeletal Service (MSK) *	Review & procurement of new service w.e.f September 2014 & arrange embedding in local contract arrangements	R	D	R	R	P	P	I	R				New provider(s) confirmed to commence Sept 2014	4C, 4.1	CQUIN	£0
9,11,20	MSK Diagnostics Assessment & Treatment Service (MCATS) *	Borough wide direct access to range of diagnostics including MRI, Ultrasound, XRAY & Bloods	I	I	R	R	P	P	I	R				Swift access for patients to confirmed diagnosis, treatment, management and care. Reduction in Trauma & Orthopaedics & Rheumatology o/pt& follow up appointments	4C, 4.1	Commercial activity	£946

2,3,8,20	Diabetes Services	Redesign of diabetes services	D	P	I	R								Reduced outpatients attendances Reduced admissions	4b,c 1.1, 2.1	Commercial Digital first		£855
11,20	Gastroenterology	Review of current service with view to service redesign	S	D	P	I								Clinical audit Reduction in GP referred first OP	4b	Commercial activity		£100
9,17	Development and full utilisation of Planned Care Centre	Review and redesign of services commissioned at Beckenham Beacon	S	D	I	R								Establishment of a stakeholder reference group agreed plan for full occupancy of space vacated by SLHT achievement of full occupancy	4c	Commercial		£2,266
15,20	Specialist telephone & advice service	Fracture patients at A&E to be discharged with advice and followed up by telephone												Reduced A&E sourced T&O fracture clinic first OP attendances	4b	Digital 1st		£140

			D	I	R												
	GRASP (Atrial fibrillation stroke prevention) *	Risk stratification tool in primary care to identify patients with AF and ensure optimise medication	I	I	R									System installed across primary care and patients' medication review completed	1.1, 2.1		£0
20	Patient Transport Service	Review current service as SLA expires Sept 2013	D	P	I	R								THE CCG to directly commission new service	4b	Commercial	£300
20	Patient Transport Service	Resolve future commissioning arrangements	S	D	I	R								Review complete Plan for future revision agreed Future service commissioned	4b	Commercial	
9,17,18	Orpington H&WB Centre	Lead on the design of planned care services within the H&WB Centre												A plan is agreed	4c	Commercial	£500

			S	S	S	D	P	P	P	P	I	I	R	R				
20	Pathology Service	Re-procurement of current service	R	S	D	P	I	R							CSU-led project group established Review report New service model if evidenced case for change New service in place Reduce cost	4.1	Commercial Digital first		£960
9,20	Leg Ulcer Service *	Establishment of current pilot to ensure borough wide access for all	I	R											Borough wide service available Reduced healing times Reduced dressing costs	4.1, 2.1	CQUIN		£-108
20	SLHT acute efficiency	Performance measures re outpatient follow up; C2C referrals, procedures of limited clinical effectiveness	S	I	R	R	R										Commercial		£2,890
Totals																			**£12,196**

5. QIPP Plan

						FULL SAVINGS (NET)		
Scheme	Description	Strategic Programme	Area of spend	R/NR	2012/13 Forecast outturn	2013/14 Plan	2014/15 Plan	2015/16 Plan
					£'000	£'000	£'000	£'000
Brought Forward Schemes								
Gynaecology	Review effectiveness of new services & arrange handover to THE CCG Contract Management Team	Planned Care	Acute Contract		£160	£425	£0	£0
Dermatology	Review effectiveness of new services & arrange handover to THE CCG Contract Management Team	Planned Care	Acute Contract		£164	£363	£0	£0
New Schemes (Firm)								
Anticoagulation	Re-specify and re-procure service	Planned Care	Acute Contract		£255	£517	£258	£0

Cardiology	Development of Intermediate based service	Planned Care	Acute Contract		£0	£331	£331	£0
Cardiology	Avoidance of cross-provider multiple admissions	Planned Care	Acute Contract		£0	£361	£361	£0
MCATS	New borough wide service: direct access to range of diagnostics including MRI, Ultrasound, XRAY & Bloods	Planned Care	Acute Contract		£0	£908	£38	£0
Diabetes	Redesign	Planned Care	Acute Contract		£0	£103	£361	£391
To Be Developed								
Gastroenterology	Review of current service with view to service redesign	Planned Care	Acute Contract		£0	£100	£0	£0
Planned Care Centre	This is a major project aimed at making full utilisation of the space at Beckenham Beacon coming out of the TSA, scoping & design in Year 1	Planned Care	Acute Contract		£0	£0	£933	£1,333
Telephone Clinical Advice (T&O)	Swift access for GPs to discuss patient care with T&O consultant	Planned Care	Acute Contract		£0	£70	£70	£0
GRASP (stroke prevention)	Rollout of GRASP risk stratification tool in all practices	Planned Care	Acute Contract		£0	£0	£0	£0

Patient Transport Service	Re-specify and re-procure service as current contract expires Sept 2013	Planned Care	Acute Contract		£0	£100	£200	£0
Patient Transport Service	Resolve current management arrangements	Planned Care	Acute Contract		£0	£400	£0	£0
Orpington Centre	Redesign of services to occupy new Health & Well Being Centre to be built in Orpington	Planned Care			£0	£0	£0	£500
Pathology Procurement	Re-specify and re-procure service	Planned Care	Acute Contract		£0	£0	£960	£0
Leg Ulcer service	Establishment of current pilot to ensure borough wide access for all	Planned Care	Acute Contract		£0	-£36	-£36	-£36
SLHT acute efficiency	Performance measures re outpatient follow up; consultant to consultant referrals; Procedures of limited clinical effectiveness etc	Planned Care	Acute Contract		£0	£2,890	£0	£0
Total					**£579**	**£6,532**	**£3,476**	**£2,188**

6. Governance

Governance & Decision Making Arrangements:

The Planned Care Programme underwent a rigorous process of approval in line with the CCG's governance structure and will be submitted to the Governing Body for approval at its first meeting on 18th April 2013. Following that, the Planned Care Programme Group will progress the approved list of projects set out in the delivery table. As stated, in some instances the projects represent work that is already underway and will be carried forward. The Programme Group will ensure delivery of any proposed QIPP savings, consider quality, clinical effectiveness, and value for money to work up project plans and business cases for each project. The Planned Care Programme lead will present project plans and business cases to the Strategic Planning Group to seek its onward recommendation. The Strategic Planning Group will consider their strategic fit with the programme that has been approved and make recommendations to the Clinical Executive for approval. In some instances, the Clinical Executive will recommend to the Governing Body for decision. This is relevant for example when section 256 funding is required for release or where the size and scale of the project has significant ramifications for the CCG and its population. Once project plans and business cases are approved, the Planned Care Programme lead will provide a routine programme overview and exception reports to the CCG Programme Delivery Group, during the implementation and review phases.

Programme Membership

Chair	CCG GP Clinical Lead
Clinician	GP
Senior Responsible Officer	Director of Healthcare System Reform
Programme Lead	Associate Director of Development
Programme Manager	Senior Care Pathway Manager
Quality	Director of Quality, Governance & Patient Safety
Prescribing	Head of Medicines Management (as required)
Public Health	Consultant in Public Health
Finance	Head of Finance
Performance	Head of Performance
Acute Contracting	CSU Acute Contracting Lead

Members may nominate a designate who is empowered and capable to act. The success of the Planned Care Programme will rely on continued enhancement of multidisciplinary primary and community services, integrated with social care services that support people with long term conditions, enabling them to be cared for in the community and empowering them to self manage their care wherever possible. With this is mind, it is recognised that there will be linkages within the Planned Care Programme and the Programmes for ProMISE (Integrated Care), Unscheduled Care and Primary Care. The Planned Care Programme will need to ensure proactive compliance with the arrangements that are in place to address such linkages.

In particular, the Planned Care Programme will continue to work with colleagues on the Primary Care Programme with the aim of maximising GP engagement in order to fully realise the benefits of the care pathways that have been, or are being, redesigned.

Bromley Clinical Commissioning Group

BROMLEY

2.3 UNSCHEDULED CARE STRATEGIC PROGRAMME

2013-16

1. Profile

The Integrated Commissioning Plan 2012-15 identified Unscheduled Care as one of six strategic programmes as vehicles for the delivery of improvements that are required to the healthcare system in Bromley. Provision of healthcare through A&E and emergency admissions is often anxiety provoking and inconvenient for patients and only meets their health needs when they have reached a crisis point. It may mean, therefore, that patients face becoming more unwell than would be necessary if their health needs were being met in a more planned way. Contact with healthcare professionals in emergency settings is provided by clinicians that are trained to handle life threatening conditions and, therefore, their skills and resources are best utilised for this type of situation. Primary care sensitive and long term conditions can be cared for in other settings thus making more efficient use of NHS resources.

Therefore, the aim of the Unscheduled Care programme is to pre-empt attendances to A&E, emergency admissions and readmissions, and unnecessarily lengthy hospital stays by placing more, improved, and joined up services in place to care for patients before admission becomes necessary or following discharge from hospital.

To achieve such changes, we will need to work with providers to reconfigure and develop services to maximise benefits and efficiencies for the population of Bromley. There are two Urgent Care Centres in Bromley, one at the Princess Royal University Hospital (PRUH) which acts as a front end to A&E and one at Beckenham Beacon. Analysis shows that commissioning the PRUH Urgent Care Centre has resulted in a reduction in A&E activity by 38%, however, there has not been a corresponding reduction in overall urgent activity of a similar amount thus demonstrating an increase in demand overall. Both Urgent Care Centres attendances and Out of Hours activity have shown growth over the past two years.

Comparatively, Bromley patients access urgent care services less than neighbouring Bexley or Greenwich patients, about 525 contacts per 1,000 population. Children and young people account for by far the greatest number of contacts, in particular 0-10 year olds make up 21%. This proportion is comparable across BBG and Lewisham. Older people aged 80+ are also high users even taking into consideration that Bromley has the largest population of older people in London. Thirty two percent of contacts are made on weekdays between 08.00 – 18.00 when GP practices are open. The admission conversion rate of 0-5 year olds is 10% at the PRUH which is higher than for other neighbouring hospitals. Admission conversion rates at the PRUH are 33% overall as compared to the national average of 22%. The rate has increased significantly in the past two years. Furthermore, the conversion rate varies widely throughout the day. In keeping with Bromley's older patient age profile, over half of emergency admissions at the PRUH are of patients aged over 65. Of the top 10 presenting complaints for 0-5 year olds at the PRUH, 'unwell child' is by far the highest. Bromley children and young people are also high presenters at New Cross walk-in centre (in Lewisham) accounting for 23%.

Spend figures for 2012/13 for service elements of Unscheduled Care total £101 million. Below is a table which depicts 2012/13 figures. The services commissioned are from NHS and non NHS providers and deliver health and social care services across Bromley Hospital.

Fig 1. Programme Budget 2012-13

Service Area	Forecast Outturn activity 2012-13	Forecast Outturn 2012-13 £ 000's
UCC PRUH	41,530	£2,104
UCC at Beckenham Beacon	31,457	£1,448
Emergency Department Attendances	97,231	£11,960
Intermediate Care step down beds	315 13,759 bed days	£1,199[2]
Intermediate Care community service - CARTS	398 22,410	£2,253
Emergency admissions	32,492	£78,659
Excess bed days (cost included in emergency admissions)	15,752	£0
Rapid Response	3421	£649
Cator Practice (Walk in element)	7265	£394
PACE		£670
SCRehN (Specialist Community Neuro-rehab) & ESD (Early Supported Discharge for Post Stroke patients)	4819	£878
Transforming Community Equipment Service – online access across health and social care	block	£800
TOTAL		**£101,014**

[2] Reduction from 40 beds to 20 beds on Orpington Hospital site

2. Health Needs

The rationale is to ensure appropriate commissioning strategies for the borough which has the largest ageing population in London [15.6%]. In addition to this, birth rates since 2002[3] have increased and are increasing with rising population in the borough's 0-4 year old age group.

Bromley has an older population than the London average which is due to increase slightly over the next decade. There is an increase in the prevalence of the following medical conditions and diseases among the older population.

Fig 2: Statistics of disease and conditions in Bromley

Condition	Numbers in Bromley 2011/12
Hypertension	52 000
Diabetes	13 335
Stroke	5 935
COPD/Respiratory	4 804
Dementia	1 927
New Cancer diagnoses	1 661
Patients managing cancer	6 296

- Prevalence of hypertension - Bromley is above national average
- Increasing number of patients with Diabetes
- High incidence of COPD and other respiratory diseases
- Largest over 65 population in London resulting demand on Dementia services
- Long term neurological diseases are on the increase

Patients need support to manage these long term conditions with a package of care comprising urgent care, intermediate care and rapid response to manage presenting symptoms to sit alongside proactive case finding.

The absence of particular services in the community and / or limited capacity in primary care has an impact on the number of admissions to beds. Additionally, acute trust avoidance of the breach of the 4-hour A&E waiting time pledge may lead to patients being admitted to a ward when admission may not always be clinically necessary.

National evidence and research demonstrates independence declines rapidly amongst the older population when admitted to an acute bed environment. Commissioning an Urgent Care service as the front end of A&E will ensure that patients are seen in a timely manner and the appropriate intervention is provided instead of an acute admission.

[3] Census 2011

3. Strategic Context

National & Local Case for Change

There is a national requirement that people are treated and cared for in a safe environment and protected from avoidable harm. Implementation of NHS 111 will initiate some consistency of unscheduled care across London and England. The service will reduce the use of 999 emergency services and provide alternative lower cost urgent care for non life-threatening medical emergencies. This will also provide an alternative care pathway for non-life threatening patients who arrive in an ambulance.

By commissioning and procuring appropriate unscheduled care services with shorter response times (2 hours as compared to 4 hours) patients with urgent clinical need can be seen outside an emergency environment and reduce the risk of being admitted to a hospital bed. The programme will focus on services which facilitate timely interventions which in turn promote regaining of independence with appropriate rehabilitation services in the most optimum settings which includes patients' own homes.

Patients who need to access emergency services will be fast tracked from urgent care to emergency department where appropriate. The system will ensure that those who can be seen, treated and diverted back to community or primary care are also discharged in a timely manner to enhance and improve the patients' experience. The CCG has identified emergency readmissions within 30 days of discharge from hospital as one of its three local priorities for improvement in 2013-14. Bromley has experienced an upward trajectory on a 1,000 head of population basis over the past ten years against this measure and performs less well than the national average. This is comparable, however, with other South East London CCGs and London Thriving Periphery CCGs.

The key recommendations of the Secretary of State's decision on the Trust Special Administrator's report for Bromley CCG are:

- Princess Royal University Hospital (PRUH) to be run by King's College Hospital
- More effective use of Beckenham Beacon as a facility for delivery of health services
- Disposal of Orpington Hospital and relocation of services to other local sites
- Implementation of the Community Based Care (CBC) strategy at greater scale and pace

The priority of this programme is to deliver a range of benefits to improve patients' experience, promote independence by delivering care in patients' own homes (including care homes), early intervention with anticipatory care, rapid access to care services and equipment to support care in the community to avoid inappropriate hospital attendance and admissions and timely discharges from an acute bed. A local example already in place is the comprehensive specialist post stroke care pathway which ensures that patients receive the optimum level of stroke rehabilitation by providing early supported discharge with community rehabilitation. This pathway provides the highest possible level of return to independence and prevention of re-admissions.

The CCG and London Borough of Bromley currently jointly commission/procure the following schemes within this programme:-

- Joint re-ablement service/schemes

- Joint Intermediate Care services
- Joint Transforming Community Equipment Service
- Domiciliary care joint framework
- Joint respite provision to provide a variety of options (at home, care homes, sitting services)

The CCG will work with its partners and providers to promote innovation, rapid responses, flexibility and capability to cope with the demands of this strategic programme

4. Delivery Table

Delivery Table			2013-14				2014-15				2015-16				How Success will be Measured	National Outcomes Indicators / Operating Framework 2013-14	High Impact Innovations	Project Value £000's
Scope : Design : Procure : Implement : Review :			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4				
Strategic Objectives	**Key Areas**																	
1,2,6,8,9,10,12,13,15,16,17,20	**Rapid Response & Step Up service**	Case finding within A&E, working with hospital clinicians to identify those who can be supported at home rather than being admitted to hospital, Responding to GP referrals,	I	I	I	I	R	R	R	R					**Increase of throughput numbers to the service, Reduction in admissions to acute services by 150 per month, Reduction in preventable nursing home placemen**	1, 3, 3.6, 4.2, 4.9, 5	Step up beds in community and improved Rapid Response service	£1,500

		Care home support, community beds														**ts**			
1, 2, 8, 9, 12, 13, 15,16,17, 18,20	**Intermediate Care** type services & step down beds	Procurement of beds and redesigned community services	**S**	**P**	**P**	**I**	**I**	**I**	**I**	**R**	**R**	**R**	R			**Reduction in commissioned beds by 20, shorten average length of stay in intermediate care bed, Increased usage of IC beds for complex conditions**	1, 3, 3.6, 4.2, 4.9, 5		£600
	Bereavement Counselling	Full year delivery effect of existing scheme																	£50

	Urgent Care Centre at Beckenham Beacon	Reconfigure existing service	D	P	I	I	I	R	R						**GP led Urgent Care Centre, Increased use of UCC to a target of at least 50% of all A&E attendances (approx 60,000 pa), Reduction in admissions to acute settings**			£500
1, 2, 8, 9, 12, 13, 15,16,17, 18,20	**Urgent Care Centre at PRUH**	Provision of Urgent Care Services for non ED conditions 24/7, reconfigured, staffed and equipped for both minor	D	P	I	I	I	R	R							1, 3, 3.4, 3.5, 4.2, 5		£1,525

		ailments and minor injuries, see and treat when possible															
	Elmstead decommissioning	Revisions to the pathway are already in place and reduce previous level of expenditure															£300
6,8,9,10,12,13,15,16,17,20	**NHS 111**	Pilot procured by SL CSU	I	I	I										1, 4.3, 5	Reviewed clinical protocols and improved care pathways	£0
	Transforming Community Equipment Services	Online service across health and social care provided by Mediquip	R	R	R	R											£300
	Total																**£4,775**

5. QIPP Plan

						FULL SAVINGS (NET)		
					£'000	£'000	£'000	£'000
Scheme	Description	Strategic programme	Area of spend	R/NR	2012/13 Forecast outturn	2013/14 Plan	2014/15 Plan	2015/16 Plan
Rapid Response	Reconfigure to include greater step up capability with impact on emergency admissions	UC	Acute	R		£500	£1,000	£0
Intermediate Care Service – Step Down	Reconfigure current service	UC	Client groups	R		£300	£300	£0
Bereavement Counselling	Implemented	UC	Client groups		£50	£50		£0
Urgent Care Centre at Beckenham Beacon	Procure and implement service	UC	Client groups			£500		£0
Urgent Care Centre at PRUH	Redesign and reprocure to reduce activity to 50%	UC	Acute		£525	£1,275	£250	£0
Elmstead decommissioning		UC	Client groups			£300		£0
NHS 111	Implement & Roll out in line with national objectives	UC	Acute contract	R		£0		£0
Transforming Community Equipment Services	Implemented	UC	Client groups			£200	£100	£0
Total					**£575**	**£3,125**	**£1,650**	**£0**

6. Governance

Governance & Decision Making Arrangements:

The Unscheduled Care Programme underwent a rigorous process of approval in line with the CCG's governance structure and will be submitted to the Governing Body at its first meeting on 18th April 2013. Following that, the Unscheduled Care Programme Group will initially scope and design the approved list of projects set out in the delivery table. As stated, in some instances the projects represent work that is already underway and will be carried forward. The Programme Group will ensure delivery of any proposed QIPP savings, consider quality, clinical effectiveness, and value for money to work up project plans and business cases for each project. The Unscheduled Care Programme lead will present project plans and business cases to the Strategic Planning Group to seek its onward recommendation. The Strategic Planning Group will consider their strategic fit with the programme that has been approved and make recommendations to the Clinical Executive for approval. In some instances, the Clinical Executive will recommend to the Governing Body for decision. This is relevant for example when section 256 funding is required for release or where the size and scale of the project has significant ramifications for the CCG and its population. Once project plans and business cases are approved, the Unscheduled Care Programme lead will provide exception reports on an ongoing basis to the CCG Programme Delivery Group during the implementation and review phases.

Programme Membership

Chair	CCG GP Clinical Lead
Clinician	GP (subject to funding being agreed)
Senior Responsible Officer	Director of Healthcare System Reform
Programme Lead	Associate Director of Integrated Commissioning & Partnerships
Quality	Director of Quality, Governance & Patient Safety or designate
Prescribing	Head of Medicines Management
Finance	Chief Financial Officer or designate
Performance	Head of Performance or designate
Acute Contracting	CSU Acute Contracting Lead

Members may nominate a designate who is empowered and capable to act. The success of the Unscheduled Care Programme will rely on continued enhancement of multidisciplinary primary and community services, integrated with social care services that support people with long term conditions, enabling them to be cared for in the community and empowering them to self manage their care wherever possible. With this is mind, it is recognised that there will be linkages between the Unscheduled Care Programme and the Programmes for ProMISE, Planned Care, and Primary Care and that the Unscheduled Care Programme will need to ensure proactive compliance with the arrangements that are in place to address such linkages.

In particular, the Unscheduled Care Programme will continue to work with colleagues on the Primary Care Programme with the aim of maximising GP engagement in order to fully realise the benefits of the care pathways that have been, or are being, redesigned.

Bromley Clinical Commissioning Group

Bromley

2.4 PRIMARY CARE STRATEGIC PROGRAMME

2013-16

1. Profile

Primary care refers to services provided by GP practices, dental practices, community pharmacies and optometrists; about 90% of contacts with the NHS are with primary care services.
There are now forty-six GP practices in Bromley, ranging from small single-handed practices with a list size of 2,000 patients or less to large multi-GP practices with a list in excess of 17,000 patients.
The total GP registered population in Bromley, the largest of the London boroughs, is in excess of 340,000 and of that population 16.2% and rising are older people, constituting the largest ageing population in London.
In addition to GP practices and their supporting clinical and non-clinical workforce there are many community pharmacies, dental and ophthalmic practitioners providing NHS primary care services to the people of Bromley.
For the CCG, of great strategic importance will be the pivotal role that Primary Care and in particular GP practices will need to play in delivering and supporting healthcare system reform within Bromley both now and in the future; particularly so in the light of the Trust Special Administrator (TSA) report and the associated Community Based Care strategy which will be implemented at pace across South East London.
At the same time, the CCG will also need to consider and address through this programme local challenges for Primary Care in Bromley

- Approximately one-third of the GP workforce in Bromley is at or approaching retirement age, many of them single-handed GPs (in recent years, the number of GP practices in Bromley has reduced from 53 to 46) placing greater strain on the existing workforce and infrastructure
- Many patients want the personal levels of care that single-handed GP practices are able to offer and the CCG will need to find ways to enable this to continue whilst enabling these smaller GP practices to meet the growing demands and pressures upon them to perform
- Our practice nurse workforce is also ageing, whilst also being asked to undertake more clinical activities to allow GPs to focus their time on the patients with the most complex needs, and the CCG needs to find ways to develop the skills required whilst encouraging nurses into Primary Care
- Relatively low levels of satisfaction with access to GP services and patients with long-term conditions not feeling particularly well- supported in managing their condition
- Existing challenges with Primary Care estates in terms of capacity and the availability of facilities to meet current as well as future demands
- IT infrastructure that is largely standalone and lacks capacity for expansion
- A relative lack of effective engagement and collaboration to date with primary care services beyond GP practices meaning that opportunities for innovation and collaboration are being lost

In 2012/13, the predicted investment in contracted Primary Care services is as follows:

Primary Care Commissioning Budget	Forecast Outturn 2012-13 £ 000's
GP Practice Medical Services	£38,828
Ophthalmic Services	£2,571
Pharmacy Services	£8,444
Dental Services	£11,352
Primary Care Prescribing	£52,020

Total	**£113,215**

In 2013/14, the NHS Commissioning Board will be responsible for commissioning and managing the Primary Care services contracts, excluding prescribing which will be managed locally, Bromley Clinical Commissioning Group will, however be expected to assist and support the NHS Commissioning Board in securing continuous improvement in the quality of Primary Care. Significant investment already made in earlier years provide the foundation for delivering the transformational changes required and the projects described in the programme will continue, be reshaped and be added to as our model for Primary Care in Bromley becomes clearer

Primary Care Programme Budget 2012/13			
Service/Scheme	**Recurrent (R) Non-Recurrent (NR)**	**Budget**	**Forecast Outturn £ 000's**
GP Practice Incentive Scheme	NR	£130	£87
GP Practice Investment Scheme	NR	£300	£244
Prescribing incentive scheme	NR	£60	£60
Academic half-days & Protected Time	R	£37	£37
GP Trainers Group	R	£23	£23
Model of Nursing Care	R	£10	£2
Professional Development	R	£9	£11
Training Courses	R	£10	£10
Prescribing Lead	R	£3	£3
GP meeting attendance	R	£26	£26
LMC/PMS liaison	R	£5	£5
Practice staff forum	R	£10	£10
Quality Outcomes Framework (Quality & Productivity) assessment	R	£30	£30
Ultrasound service	R	£40	£40
GP Local Enhanced Services	NR	£830	£811
Ophthalmology Enhanced Service	R	£14	£29
Pharmacy Enhanced Service	NR	£341	£363
Total		**£1,878**	**£1,791**

2. Health Needs

Bromley has a growing and already largest population of older people in London, whilst the mini baby boom of recent years has also seen an increase in 0 – 4 year olds. Older people and people with children are higher users of services and are more likely to need regular access to GP practices, pharmacies and other services.

In Bromley, life expectancy is continuing to rise, moreover, and healthcare providers are facing increasingly complex health challenges and levels of demand.

Primary care which accounts for 90% of all contacts with the NHS, and GP practices in particular, are having to meet these growing demands in the context of a prolonged recession with increasing demands from patient with increased levels of anxiety and depression and alongside the challenges of supporting the drive to deliver care closer to home and the added responsibilities of clinical commissioning.

There are variations in population density, levels of deprivation and concentrations of black and minority ethnic population across the borough placing specific demands on primary care services in these areas.

There is a specific need to improve primary care registers and recall systems for people with learning disabilities, as there is a considerable shortfall in the numbers of people identified with learning disability who have had an annual health check.

The main causes of death in Bromley are circulatory disease, cancer and respiratory disease creating a significant burden for primary care in helping to support people living with chronic health.

The prevalence of obesity among adults and children is rising and is a key risk factor for circulatory disease and cancer but also for Type 2 Diabetes which along with hypertension continues to increase.

Furthermore, as our population ages so does the prevalence of dementia increase with the diagnosed number expected to rise from 4,000 to 6,000 by 2030, adding further to the complexity and demands of managing increasing numbers of patients with long-term conditions in primary care in Bromley.

3. Strategic Context

Findings within the Joint Strategic Needs Assessment point to challenges for the local health system to find ways to work in partnership with patients, carers and each other to prevent ill health, improve health and treat people in an integrated and more cost-effective way in primary and community settings, especially those with chronic conditions and complex care needs.
These pressures, coupled with challenges in primary care will require practices to work more closely together to improve productivity. Furthermore we will maintain and continue to utilise our GP Locum Bank as a means of recruiting younger GPs to Bromley and work with the NHS Commissioning Board, Local Education Training Board and others to manage the challenge of the ageing workforce and encourage new primary care staff to Bromley.
From our monitoring through practice profiles, the Quality & Outcomes Framework, Patient Referral Centre and hospital data, as well as national and London comparator data, we are aware that in Bromley there is wide range of variability in rates of referral and rates of admission, planned and unplanned, per 1,000 of registered population. It is our aim to reduce that variability and to bring GP practices in line with rates of referral and admission in other Thriving London Periphery CCGs.
Similarly, rates of observed prevalence, take-up of screening and immunisations are in some GP practices below what would be expected. It is our aspiration to help all GP practices in Bromley to attain identify all relevant patients living with long-term conditions and to achieve rates of screening and immunisation that place them within the top 10% for London .identify and thereby support
This strategic programme articulates the challenges, opportunities and pivotal role that Primary Care will need to play in the successful delivery of the CCG's five other strategic programmes as they help to support full implementation of the TSA recommendations and associated Community based Care strategy as well as achieving the CCG's own strategic priorities and objectives.
The recommendations in the report of the Trust Special Administrator appointed to develop a model for securing sustainable NHS services in south east London in the light of the failure of South London Healthcare NHS Trust emphasise the need to move towards a model of healthcare that ensures continued improvement in life expectancy and quality of life while addressing the challenges of a large older people's population, growth in the number of people with long-term conditions, and constrained levels of funding to the NHS.
Within this context and by way of response to that challenge, commissioners in south east London have developed their strategy for Community-based Care. For Primary and Community care great emphasis has been placed upon:

- Supporting self-management and choice
- Prevention and detection of conditions
- Access to 24/7 telephone advice and triage
- Access to 24/7 urgent primary care services; and
- Provision of care across clinical networks with consistent, high quality standards

The significant shift of healthcare activity from hospital into community settings will require a transformation in Primary Care.
The first aim of this strategic programme, therefore, is to scope and design a model for primary care delivery that will enable the changes required across the whole local health and social care system to be implemented. Once a new model of primary care has been designed and approved, implementation will be through this programme. The changes will undoubtedly lead to new collaborative ways of working across primary and community care and the voluntary sector, such as networks and federated models that are truly integrated and responsive to individual patient and population needs with a focus on quality, efficiency and outcome focused care. This will need to be supported by ways of working that enable the pooling of skills and resources, a structured programme that develops new skills and capabilities, leading to increasing specialism and the creation of new professional roles and responsibilities; real investment in capacity, supporting

systems and infrastructures as well as premises; the greater involvement of patients and patient groups in the design and delivery of services that best meet and suit their needs; and the need for a stronger public health role to support prevention and the promotion of self-care to help ease the pressures on the system.

We will only be able to realise changes of this magnitude and nature through forging strong relationships and through close collaboration and partnership working with the Local Education Training Boards, deaneries, colleges and universities, the NHS Commissioning Board and our local GP practices and other primary care providers. The CCG will need to continue to work closely and actively with its other CCG partners to realise our collective strategy for community-based care in south east London with the aim of securing sustainable NHS services. The CCG will both sponsor and lead key implementation and enabler projects, working with the south east London programme management office and key senior colleagues within the Commissioning Board. Together we will define and ensure improved and equal access to consistently high standards of primary and community care services, promoting prevention and detection and supporting self-management and choice,

The drive for increasing choice and service integration, greater focus upon prevention and detection, improved access, providing care closer to home and placing greater emphasis on patient and public involvement are a significant challenge for the general practice workforce in particular and the wider primary care workforce. This programme is designed to help Primary Care meet these challenges and to also it respond to the challenge of ‘Digital First’, one of the Department of Health’s identified High Impact Innovations.

4. Delivery Table																	
Primary Care Strategic Programme 2013-16 * Some projects have commenced		**2013-14**				**2014-15**				**2015-16**				**How Success Will be Measured**	**National / Local Outcomes Indicators / Operating Framework 2012-13**	**High Impact Innovations**	**Project Value 2013-16 £ 000's**
Scope⇨Design⇨Procure ⇨ Implement⇨Review/Handover		**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**				
Strategic Objective	**Description**																
14, 17, 20	To agree a model for primary care in Bromley that supports delivery of the CCG Integrated	**S**	**D**											A Plan has been designed and agreed Stakeholders identified and			

	Plan													reference group established Evidence of engagement in local and London-wide networks (NHSCB, CCGs, LETBs, LRCs) Wider consultation with primary care Evidence of wider public and patient involvement			£0
14	Succession planning and support to programmes	P I	R											Three GP clinical leads recruited (12 months)			-£45
1-5 18-20	Programme of educational	D	I	I	I									70% of practices sign-	4a		-£15

	activities to embed new ways of working, support the achievement of other strategic programmes and address identified quality/performance issues				R								up to PTI and/or incentive scheme 70% of GPs surveyed report that training has improved their practice/ understanding Practice Improvement Plans Practice reports on improved practice			
		I	I	I	I R								6 academic half-days GP survey 'good' or better (80%) 4 MSK Club mtgs 3 Skin club mtgs	2.1 2.6 3a&b		-£30
8-9, 14	Patient Participation	I	I	I	R								80% of practices with PPGs Patient Forum established (2	4a		-£2 -£10

14-15, 20	GP Practice Improvement Plans	D	I		R								100% of practices visited & issued performance packs	2.1 3a		£0
1, 18	Primary Care premises	R	R	R	R								Practice visits to QIPP assess business cases Reports from Estates lead to Programme Group	4a		£0
1-5, 8, 9	Medicines Adherence Support Service	I	I	R	R	D	I	I	R	D	I	I	R	70% of patients reporting that the service is good or excellent Patients report feeling better supported with their LTC than reported in 2012			£0
1-5, 8, 9	Tailored Dispensing Service	P I	I	I	R									As above			£0

	Medicines Management efficiencies, ie. Optimisation, Script Switch, oxygen, PbR exclusions, incentive scheme to support quality and cost effectiveness	D	I	I	R	D	I	I	R	D	I	I	R	Reviews undertaken			£3,000
1, 8, 9, 11, 18	Incentive Scheme	I	I	I	I	R								100% Practice sign-up Falls & Carers Registers Increased referrals to PRC to 75% along incentivised pathways Achievement of associated Cost Improvement targets C&B utilisation to 60% Patients report feeling better supported with their LTC than reported in 2012	2.1 2.4 3a&b	Digital First	-£208
1, 2, 4, 5, 8, 18,	Investment scheme	I	R											Interim reports March 2013	2.1 3a&b		£0

1,17	Patient Liaison Officer Programme	R	D	I	I	R								Workshops delivered Evaluation Report Next stage business case with clear job description and deliverables agreed	2.1 4a		-£250
18, 20	Local Enhanced Services	R	R	D	P	I	R	R	R					Local management in place by 1 April Proposal on future commissioning by end Q2 Services procured and new contracts in place by 4/14	4a		-£860
		I	I	I	R												

14, 15	Practice Manager and Practice Nurse involvement	I	I	I	R									3 meetings per group Representation at CCG meetings Workforce development plan			-£6
20	Primary Care Dashboard	D	I	I	R									Performance Team and NCB development plan			£0
	Investment in Primary Care across years 2 and 3 to support plan for development				D	I	I	I	I	I	I	R	R	Delivery of KPIs in model to be agreed			-£2,852
TOTAL																	**£1,278**

5. QIPP Plan

						FULL SAVINGS (NET)		
Scheme	Description	Strategic Programme	Area of spend	R/NR	2012/13 Forecast outturn	2013/14 Plan	2014/15 Plan	2015/16 Plan
					£'000	£'000	£'000	£'000
New Schemes (Firm)								
Medicines Management	Collection of schemes for prescribing efficiency across the whole system to result in net savings	Primary Care	Prescribing		£ 1,118	£ 1,000	£ 1,000	£ 1,000
LES Review	Withdrawal of incentive scheme pump priming that formed part of previous PBC arrangements	Primary Care	General Practice				£ 860	
Total					**£ 1,118**	**£ 1,000**	**£ 1,860**	**£ 1,000**

6. Governance

Governance & Decision Making Arrangements:

The Primary Care Programme underwent a rigorous process of approval in line with the CCG's governance structure and will be submitted to the Governing Body at its first meeting on 18th April 2013. Following that, the Primary Care Programme Group will initially scope and design the approved list of projects set out in the delivery table. As stated, in some instances the projects represent work that is already underway and will be carried forward. The Programme Group will ensure delivery of any proposed QIPP savings, consider quality, clinical effectiveness, and value for money to work up project plans and business cases for each project. The Primary Care Programme lead will present project plans and business cases to the Strategic Planning Group to seek its onward recommendation. The Strategic Planning Group will consider their strategic fit with the programme that has been approved and make recommendations to the Clinical Executive for approval. In some instances, the Clinical Executive will recommend to the Governing Body for decision. This is relevant for example when the size and scale of the project has significant ramifications for the CCG and its population. Once project plans and business cases are approved, the Primary Care Programme lead will provide overview and exception reports on an ongoing basis to the CCG Programme Delivery Group, during the implementation and review phases.

Programme Membership

Chair	CCG GP Clinical Lead
Clinical Lead	GP
Clinical Lead for Education	GP
Senior Responsible Officer	Director of Healthcare System Reform
Programme Lead	Associate Director of Development
Finance	Chief Financial Officer or designate
NHS Commissioning Board	Associate Director of Primary Care
Programme Manager	Learning & Development Manager
Performance	Head of Performance or designate
Quality	Head of Prescribing
Practice Management	Practice Manager
Practice Nursing	Practice Nurse
LMC	LMC Representative
Patient	Patient representative

Extended membership

Public Health	As required
Other Local Representative Committees	As required
Local Education Training Board and other educational institutions	As required

Members may nominate a designate who is empowered and capable to act. The success of the Primary Care Programme will rely on continued enhancement of multidisciplinary primary and community services, integrated with social care services that support people with long term conditions, enabling them to be cared for in the community and empowering them to self manage their care wherever possible. With this is mind, it is recognised that there will be linkages between the Primary Care Programme and every other programme and that the

Primary Care Programme therefore will need to ensure proactive compliance with the arrangements that are in place to address such linkages.

BROMLEY

2.5 ProMISE STRATEGIC PROGRAMME

2013-16

1. Profile

In 2012 Bromley Clinical Commissioning Group developed a three year Integrated Plan outlining the priority areas for shaping and delivering healthcare to Bromley's population. Long term conditions and care for older people was identified as one of six strategic programmes, focusing on systemic change of care delivery, integration of services and a proactive and holistic approach to managing patients. In the same year this programme was branded as P*ro*MISE.

At present, many of today's primary and community care services are reactive in nature and deliver care that is fragmented, requiring the patient (or their relative or carer) to navigate their own way through a health system that is not always orientated around the individual. Consequently, too many people face inconvenience when they require unscheduled care, and services are inefficient. Therefore radical cultural, operational and service change is required to achieve the CCG's ambition to deliver personalised and integrated care.

This programme predominantly, (but not exclusively) focuses on services for older people, and includes a variety of major projects that will help more people to manage their own health at home, using a variety of support networks and home-based technologies, and very much echoes the philosophy behind the Prime Minister's "Big Society".

Community services will be radically reorganised around local populations and their General Practices, improving communications between health and social care professionals. This enables their skills and knowledge to be more easily shared, reducing the need for people to receive unnecessary multiple home visits and trips to the local hospital. These teams will ensure that people's social, physical and mental health needs are addressed simultaneously and care delivered seamlessly by local multi-skilled professionals. This initiative will make it easier to engage more effectively with voluntary groups and also help to foster a federated approach to primary care, whereby the specialist skills of clinicians can be made available not only to their own registered patients, but shared for the benefit of the wider local community.

In addition, risk stratification tools and new innovative clinical monitoring systems will ensure that residents are proactively managed to reduce their chances of requiring unscheduled care that they may also find inconvenient. Gerraint Lewis' research "Predictive Modelling in Action" suggests that a significant reduction to emergency bed days can be demonstrated with the use of case finding and proactive intervention before their "intensive year" of care and treatment.

The programme will also lead the introduction of many new services that will both improve patient outcomes and reinforce a culture of prevention and coordination amongst health and social care professionals. These services include a comprehensive falls and fracture prevention service, simple home diagnostics and associated tele-health initiatives, expert patient programmes, support for more timely diagnosis in nursing and residential homes and enhanced end of life services. The accompanying Unscheduled Care programme is also exploring options to develop additional intermediate care services, which together with this and other CCG programmes will enable considerably more people to be cared for safely in the community.

Crucial to the success of this programme is the recognition that these improvements need to be implemented across the whole of Bromley. Piecemeal service developments and ad-hoc changes to team working will not deliver the scale of service change that is required. The purpose of this programme is to bring about a fundamental change to the way in which primary and community care services are organised and delivered, and provide local professionals with new service options to help people remain as independent as possible.

Programme Budget

The programme budget for ProMISE stands at £7.5 million, which is held under Section 256 with the London Borough of Bromley. This budget is non-recurring monies, which is proposed to be used to pump-prime services and the system to radically improve the health and social care delivery and provision for older people and long term conditions.

Table 1 below highlights the current key areas of NHS expenditure on services for older people:

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Service Area	Forecast Outturn 2012/13 £ 000's
A & E Attendances	2,938
Unscheduled admissions	37,506
Continuing care	3,413
Mental Health (Older people)	135
District Nursing	5,203
Hospice	2,324
Total	**£51,519**

Table 1- Current spend on services for people over 65

2. Health Needs

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

Demographic figures quoted the Bromley registered population of 331,465[4]. Elderly people represented 17.6% of Bromley residents in 2011, equating to 54,000; the greatest concentration of elderly in London. It is expected that this will increase to 57,000 (an increase of 5%) by 2015 and will continue to increase to 74,100 (by 37%) by 2030. With residents living longer but with a range of health and social conditions, greater pressure is being put on the system. As demonstrated in the JSNA, the implications of this are:

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

Key disease challenges in Bromley are heart disease, diabetes, respiratory disease and dementia.

- Over the past 6 years the prevalence of hypertension has been rising, with Bromley being above national average.
- Similarly the number of patients with diabetes is increasing, which is particularly significant given it can be a precursor to heart disease, stroke, or chronic kidney disease.
- Respiratory conditions are prevalent in the area also and represent almost 13% of total deaths in Bromley, including influenza and chronic obstructive pulmonary disease (COPD).
- There is under-diagnosis of dementia in comparison to local prevalence in the over 65s population and therefore further emphasis is required to identify and treat the condition.

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

Finally, the continuous rise in numbers of residents with diagnoses of hypertension and type-2 diabetes give cause for two of the CCG's disease areas of predominant concern, and hence the focus on developing and improving services aimed at proactively ensuring their care is well planned and monitored to avoid placing them at high risk of deterioration..

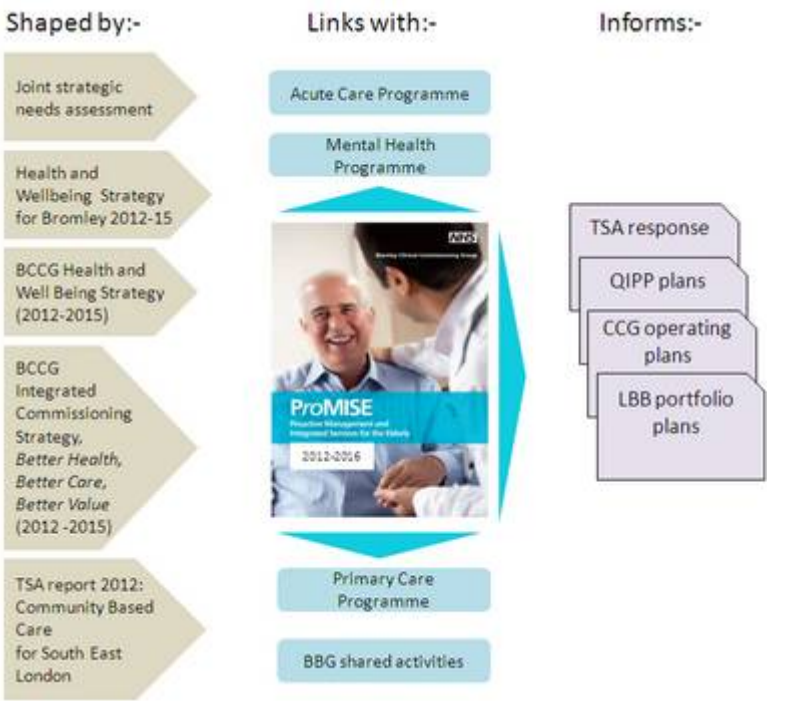
[4] Taken from registrations with local GP practices from 31/12/2012 derived from the Exeter system

3. Strategic Context

The coalition Government has emphasised the need to give priority to improving services for the elderly and those with long-term conditions, stating that "by 2015 every health economy should be able to demonstrate high levels of care coordination or integration". In addition the NHS Outcomes Framework 2013-14 has further mandated the importance of demonstrating and evidencing health outcomes, many of which relate to both the elderly and long-term conditions, for example Domain 2: Enhancing quality of life for people with long-term conditions; Domain 3: Helping people to recover from episodes of ill health or following injury; Domain 4: Ensuring that people have a positive experience of care.

The January 2013 publication of the Trust Special Administrator's (TSA) draft report: Securing Sustainable NHS Services, that aims to address the long-standing issues at South London Healthcare NHS Trust, very much reflects existing CCG service priorities. Therefore the P*ro*MISE programme is already well aligned to deliver the objectives of the Community based Care Strategy for South East London.

The diagram below depicts the relationship between the programme and the main strategic and operational plans within the CCG and LBB. The programme will also liaise with Bexley and Greenwich CCGs on relevant shared activities.



This programme has been developed to manage and co-ordinate a wide range of innovative large scale projects to deliver the overall strategic priorities of the statutory agencies.

4. Delivery Table

Delivery Table			2013-14				2014-15				2015-16				How Success will be Measured?	National/Local Outcome Indicators	High Impact Innovations	Project Value £000's
Scope : Design : Procure : Implement : Review			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4				
Strategic Objectives Number	**Integrated services for older people**																	
1, 4, 5, 12, 16, 18.	Establish proactive case management for elderly people	Roll out current pilot across all practices	I	I	I	I	I	I	I	I	R	I			1011 fewer urgent care admissions & no increase in residential or nursing home placements	2.2, 2.3, 2.6, 4.6, 4.9	Support for carers with people with dementia	£1,834

1, 5, 12, 15,16,17,18, 20.	Create multi-agency integrated care teams	Establish 9 new zone teams	D	I	I	I		R	I							2.2, 2.3, 2.6, 3.6, 4.6, 4.9		
1, 4, 5, 10, 12, 13, 15, 16, 17, 18, 19, 20.	New community services	"step up" beds & virtual ward	**This project is to be delivered by the unscheduled programme**													2.2, 2.3, 2.6, 3.6, 4.6, 4.9	Support for carers of people with dementia	
1, 10, 12, 13, 15, 16, 17, 18, 20.	Falls and fracture prevention	Procure new models of care and prevention	D	P	I	I		R	I						177 fewer fracture admissions	3.5, 4.9		£247
1, 10, 16, 18, 20.	Better community management of UTIs	To focus on nursing and residential homes	P	I	I	I		R	I						50% fewer A & E visits & 50% fewer admissions for UTIs	2.1, 2.2, 2.4, 4.6, 4.9		£243

1, 12, 15, 17, 18, 19, 20.	Better coordinated end of life services including Coordinate My Care	New consistent end of life pathway	S	D	P	I		R	I			48 fewer urgent care admissions	4.6, 4.9	Digital First	£72
2, 3, 4, 8, 12, 15, 17, 18, 20.	Self-care, Expert patient programmes, home monitoring	EPP, text-based tele-health and self monitoring	S	D	P	I			R	I		Fewer health contacts, 1st business case to be completed by end March 13	2.2, 2.3, 4.9	3 Million Lives & Digital First	£0
8, 16, 17, 18	Local Community Coordinators	New service to promote greater independence	S	D	I	I		R	I			Less dependency on service providers	2.1		£0
													Grand Total		**£2,396**

5. QIPP Plan

						FULL SAVINGS (NET)		
Scheme	Description	Strategic programme	Area of spend	R/NR	2012/13 Forecast outturn	2013/14 Plan	2014/15 Plan	2015/16 Plan
					£'000	£'000	£'000	£'000
Establish proactive case management	Roll-out current pilot across all practices	Integrated care	Acute contract	R				
New integrated care teams	Locality based community teams	Integrated care	Acute contract	R	0	£180	£199	£1,455
New community services	Step up /virtual ward facilities	Integrated care	Acute contract	R				
Falls and fracture prevention	New services inc falls coordinator	Integrated care	Acute contract	R	0	£103	£118	£27
Reduce UTI admissions to hospital	Training for nursing & residential homes, and domiciliary workers	Integrated care	Acute contract	R	0	£107	£136	£0
End of Life / Coordinate My Care	Integrated case management	Integrated care	Acute contract	R	0	£43	£29	£0
Total					**0**	**£432**	**£482**	**£1,482**

6. Governance

Governance & Decision Making Arrangements:

The ProMISE programme overall requires a strategic decision from both the Health and Wellbeing Board and the Governing Body of the CCG for approval of the programme overall as well as for release of funding for individual projects.

The ProMISE Programme underwent a rigorous process of approval in line with the CCG's governance structure and will be submitted to the Governing Body for approval at its first meeting on 18th April 2013. Following that, the ProMISE Programme Group will initially scope and design the approved list of projects set out in the delivery table. As stated, in some instances the projects represent work that is already underway and will be carried forward. The Programme Group will ensure delivery of any proposed QIPP savings, consider quality, clinical effectiveness, and value for money to work up project plans and business cases for each project. The ProMISE Programme lead will present project plans and business cases to the Strategic Planning Group to seek its onward recommendation. The Strategic Planning Group will consider their strategic fit with the programme that has been approved and make recommendations to the Clinical Executive for approval. In some instances, the Clinical Executive will recommend to the Governing Body for decision. This is relevant for example when section 256 funding is required for release or where the size and scale of the project has significant ramifications for the CCG and its population. Once project plans and business cases are approved, the ProMISE Programme lead will provide exception reports on an ongoing basis to the CCG Programme Delivery Group during the implementation and review phases.

Membership:	
Chair	Principal Clinical Lead, CCG
Clinical Leads	ProMISE Clinical Lead, CCG
Programme Lead	ProMISE Programme Lead
CCG	Director of Healthcare System Reform, Chief Finance Officer, Director of Governance, Quality & Patient Safety, Head of Performance
LBB	Assistant Director, Commissioning and Partnerships
In attendance:	Programme Administrator

Programme Implementation Group- is chaired by the Programme Lead and has representatives from CCG Redesign, Finance, Informatics, Quality, LBB Strategy and Commissioning Representatives, Clinical Leads and Programme Community Matron Lead. The Implementation Group is directly responsible to the Programme Group and requires its approval of all business cases before they can be recommended upward. The role of the Implementation group is an operational one, in which updates are provided, issues addressed and management of individual projects is undertaken. Members may nominate a designate who is empowered and capable to act. It is recognised that there are linkages within the ProMISE Programme and the Programmes for Planned Care, Unscheduled Care and Primary Care and that the ProMISE Programme will need to ensure proactive compliance with the arrangements that are in place to address such linkages.

Membership:	
Chair	ProMISE Programme Lead
Programme Manager	ProMISE Programme Manager
Clinical Leads	Principal Clinical Lead, Clinical Lead for ProMISE, ProMISE Darzi Fellow.
CCG	ProMISE Community Matron, Programme Administrator, Chief Finance Officer, Director of Governance, Quality & Patient Safety, Head of Performance
LBB	Strategy Manager- Commissioning, Head of Assessment and Care Management- Adult and Community Services
BHC	Joint Clinical Director

BROMLEY

2.6 CHILDREN'S AND YOUNG PEOPLE'S SERVICES (CYPS) PROGRAMME

2013-16

1. Profile

In 2012, Bromley Clinical Commissioning Group developed a three year Integrated Plan outlining the priority areas for shaping and delivering healthcare to its population. Children's and Young People's Services (CYPS) has been highlighted as one of six strategic programmes, focusing on systemic change of care delivery, integration of services and a proactive and holistic approach to managing patients. Budgets, contracts have previously and planning, have previously been managed as part of other work streams with adult services.

With an increasing pressure on public sector budgets, both the CCG and the London Borough of Bromley (LBB) are under pressure to evidence best value for money, while meeting growing health and social need within a changing demographic landscape. While both organisations are delivering key services to meet the needs of service users and patients (registered) in Bromley, budgets and fully joined-up service delivery is variable. Hence, at present, there are local systemic inefficiencies as to how money is spent on the 'whole picture' for children and young people in Bromley.

Demographically, there has been an unexpected increase in births over the last 10 years, with a predicted impact likely on services for the 0-4 population. Children's centres have reduced in number to 6 locally and key services such as Health Visiting and School Nursing are now being managed by Public Health, based with LBB. With most schools having now shifted to academy status, the ability of the CCG / LBB to directly influence school health policy and in particular school-commissioned emotional wellbeing / mental health (EWMH) services, has diminished. Consequently, there is an absence of a consistent, borough-wide, approach to evaluating and addressing EWMH need within schools. This coincides with an increase in waiting times for early intervention services within Child Adolescent Mental Health (CAMHS) services.

CCG Estimated Programme Budget 2012/13

Area of expenditure	**Forecast Outturn 2012-13 £ 000's**
Acute	£19,589
Community Services	£10,225
Continuing Care	£1,048
Other community (including breastfeeding, LES, DES, safeguarding, immunisations)	£835
CAMHS CPC	£507
Total	**£62,854**[5]

LBB: Estimated Programme Budget 2012/13

Area of expenditure	**Forecast Outturn 2012-13 £ 000's**
SEN & Inclusion	£32,775
Care and Resources	£14,634
Referral and Assessment	£5,107
Safeguarding & Care Planning	£4,743
Youth Support	£3,657
Total	**£60,916**

[5] Additional expenditure on both children and adults' services amounts to an additional £180,798,000. This means that total real expenditure on CYP is likely to be at least double this figure e.g. CAMHS expenditure is included within the adult mental health contract.

There is a need for a more in-depth analysis of the CCG and LBB spending to elicit exact expenditure on children and young people, as distinct from adult services, and to ensure best borough-wide deployment of resources to improve health and social outcomes, in partnership, for children and young people.

2. Health Needs

Bromley's Joint Strategic Needs Assessment (JSNA) 2012 details the borough's specific demographic trends and key health challenges typically associated with children and young people:

- The GP practice registered population for the CCG is 331,465[6]
- The **population of Bromley** is rising and is predicted to continue to rise.
- The **number of births** has risen considerably in recent years (an increase of 29.1% in 2011 compared to 2002) and is likely to continue to do so. This has resulted in a concomitant increase in the numbers of 0 to 4 year olds.
- The pattern of population change in the different age groups is **variable between wards**, with some wards such as Bromley Town experiencing a large rise in the proportion of young people.
- 2011 Census shows that 22.6% of the population are made up of **BME groups**. Migrants from Eastern Europe are thought to have contributed to a significant increase in BME numbers recorded between 2001 and 2011.

The CAMHS Assessment 2012 identifies the importance of taking a whole community approach to emotional wellbeing and mental health. With number of referrals increasing to CAMHS services and waiting times increasing at Tier 2, it is important to consider how the broader spectrum of tiers, from 1-3 in particular, interrelate to get the right services, to the right CYP at the right time. If waiting times are increasing at Tier 2, then there may be a decreased ability locally to intervene early and prevent some problems from escalating. The JSNA 2012 indicates that levels of reported self-harm have increased in Bromley. Research indicates that early intervention and prevention are key and hence a whole community approach working with children centres, schools and GPs, as well as training for Tier 1, is worth considering to increase identification of need, increase proportion and timeliness of appropriate referrals and reduce the impact on Tier 3 / Tier 2 services.

During the past decade Bromley has experienced a significant increase in numbers of children with Special Educational Needs (SEN) and Disabilities. Increasing birth rates and advances in modern medicine have resulted in more children with disabilities and complex needs surviving at birth and into later life. The number of referrals of children to the Specialist Support and Disability Panel has increased by 19% between 2010-11 and 2011-12, an increase of 38 children, with numbers continuing to rise in 2012-13. Furthermore, while Bromley is well served by its Children's Community Nursing Team, there is a need to make the local End of Life Care pathway explicit for local people and frontline workers.

The JSNA 2012 indicates a number of vulnerable groups which require particular attention. Young carers have been identified as more likely to experience poor health and mental health with young carers providing high levels of care twice as likely to be permanently sick or disabled. Young carers can be particularly vulnerable and in need of specialist support and advice. In recent years there has been an increase in the volume of children and young people being referred to Children's Social Care services. This has resulted in an increase in the number of children becoming Looked After Children (LAC) by LBB. Health outcomes for LAC remain poor nationally with a high rate of teenage pregnancies, smoking and substance misuse, mental health problems, school drop-out rate with poor educational attainment and criminality. There are currently approximately 300 LAC in Bromley. Significantly, young first time mothers are at greater risk of lower maternity health outcomes, mental health problems and the related impact on their children. With increases in births, this vulnerable group may warrant further focus and targeted support.

[6] As of 31 December 2012 derived from the Exeter system

3. Strategic Context

CYPS is a new programme focusing exclusively on services for children and young people. The core principles guiding this programme include prevention, early intervention and **safeguarding**. The CCG is committed to delivering services in an **efficient**, **person-centred** and holistic manner which delivers **choice for patients**. The CCG recognises the importance of a whole family approach, particularly where children and young people are concerned. For these reasons, it is becoming increasingly pertinent to work ever closely with LBB colleagues to address these health and social needs together.

Consequently, in order to scope out the potential and feasibility for further integrated commissioning between the CCG and LBB this programme of work includes as a project a review of combined CYPS services in Bromley. Areas identified for further scoping include: diabetes, epilepsy, asthma, Learning Disability health checks, SALT review.

Through consultation with local stakeholders, including LBB and the voluntary sector, a number of key areas were identified: CAMHS, Complex Needs. As a result, this CYPS programme contributes to the achievement of a number of **CCG Corporate Priorities** including 'Children with Mental and Emotional Health Issues (CAMHS / Improving Access to Psychological Therapies (IAPT))', 'Children referred to Social Care (LAC)', 'Children with complex needs and disabilities (SEND Pathfinder / EOLC)' and 'High Impact Innovations (Child in a Chair in a Day)'. Furthermore, this CYPS programme contributes to the achievement of the following **CCG Strategic Priorities**: 'improve outcomes for patient diagnosed with mental health conditions)'; 'reduce health inequalities by working with LA and others to promote self-care' (Young carers, LAC, Family Nurse Partnership); 'support provider participation in research and development of new care pathways'; 'improve end of life care (EOLC pathway)'.

The development of this CYPS programme is timely, with the introduction of the **Children and Families Bill (2013)** will introduce an obligation for CCGs to provide health budgets as part of the new Special Educational Needs (SEN) regime being implemented from birth to 25. The intention is to give children, young people and their parents 'greater control' and 'choice in decision-making' so as to ensure that Education, Health and Social Care (EHC) needs are properly met. It takes forward the reform programme set out in Support and aspiration. This programme of work includes the Department of Education Special Educational Needs and Disability (SEND) pathfinder project which is currently being led locally by LBB and is the current local vehicle for scoping and developing an integrated EHC plan for CYP with complex needs.

The **NHS Mandate** reinforces the need for CCGs to focus on CAMHS and complex needs. Emphasis is placed on partnership-working with local services and improving accessibility to and waiting times for mental health services. The CYPS programme includes the development of an explicit care pathway for CYP End of Life Care (EOLC) so that professionals and service users can know which services are available to support them.

The **NHS Outcomes Framework (2013-14)** indicates a number of health outcomes relating to children and young people. These will be incorporated into a strategic CYPS programme dashboard to monitor the effectiveness of programme implementation. This programme will ensure that all children's services are required to capture and achieve high levels of patient / carer satisfaction. This information will be reported to the CYPS Programme Group on a quarterly basis. The CCG Operating Plan 2013/14 is congruent with these activities, priorities and objectives highlighting a requirement to evidence that key personnel, robust processes and quality assurance mechanisms are in place to keep children and young people safe.

4. Delivery Table

*** Please note that some projects have commenced already.**

CYPS Strategic Programme 2013-16 Scope : Design : Procure: Implement: Review:			2013-14				2014-15				2015-16				How Success will be Measured	Nat/Local Outcomes Indicators National Operating Framework 2013-14	High Impact Innovation	Project Value £ 000's
Strategic Objective Number	**CYPS Priority**	**Project**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**				
	Integrated programme development	Scoping CYP issues to determine integrated objectives and to agree projects to address them (inc. SALT review, teenage pregnancy, vulnerable groups e.g. LAC, young carers and home-educated. Recommendations to inform integrated commissioning.	**S**	**D**	**I**	**I**	**R**								Programme developed and agreed by CCG and LBB			£0

	CAMHS	Implement 'Improving Access to Psychological Therapies' for CYP / Pathway redesign T3 and T2 / Emotional Well-being Mental Health in schools	I	I	I	R	I	I	I	R					IAPT: session-by-session outcome monitoring compliant by 31 Jan 14 IAPT phase 3 completed 31 Mar 14			-£160
	Complex Needs	'Child in a Chair in a Day' – project to reduce waiting times for wheelchair services	S	D	P	R									10% reduction in av. time from referral to equip. delivery by 31 Dec 13 DH service spec fully implemented by 31 Dec 13			£0
		SEND Pathfinder – development of Education, Health, Social Care Plan	S	D	I	R									'Local Offer' available by 31 Mar 13 Personal budgets offered to all new EHCP from 30 Jun 13 EHCP offered to all new cases by 01 Sep 13	-		£0

		EOLC – formulation of explicit care pathway	S	D	I	R								Pathway completed by 31 Dec 13			£0
		Family Nurse Partnership – to improve health outcomes of young, first time mothers	S	D	P	I	I	I	I	R	I	I	I	R	Family Nurse Partnership implemented by 30 Mar 14			£0
TOTAL																	-£160

5. QIPP Plan

All of the projects included within CYPS programme are focused on improving quality, innovation and prevention.

The following projects are focused on quality and innovation: IAPT, SEND Pathfinder, Child in a Chair in a Day.

						FULL SAVINGS (NET)		
Scheme	Description	Strategic programme	Area of spend	R/NR	2012/13 Forecast outturn	2013/14 Plan	2014/15 Plan	2015/16 Plan
Child in a Chair in a Day	reduce waiting times for wheelchair services	CYP	Client Groups	R	£0	£0	£0	£0
SEND	development of special educational needs & disabilities for education, health, & social care plan	CYP	Client Groups	R	£0	£0	£0	£0
IAPT	improving access to psychological therapies	CYP	Client Groups	R	£0	-£160	£0	£0
Total					**£0**	**-£160**	**£0**	**£0**

6. Governance

Governance & Decision Making Arrangements:

The CYPS Programme underwent a rigorous process of approval in line with the CCG's governance structure and will be submitted to the Governing Body for approval at its first meeting on 18th April 2013. Following that, the CYPS Programme Group will initially scope and design the approved list of projects set out in the delivery table. As stated, in some instances the projects represent work that is already underway and will be carried forward. The Programme Group will ensure delivery of any proposed QIPP savings, consider quality, clinical effectiveness, and value for money to work up project plans and business cases for each project. The CYPS Programme lead will present project plans and business cases to the Strategic Planning Group to seek its onward recommendation. The Strategic Planning Group will consider their strategic fit with the programme that has been approved and make recommendations to the Clinical Executive for approval. In some instances, the Clinical Executive will recommend to the Governing Body for decision. This is relevant for example when section 256 funding is required for release or where the size and scale of the project has significant ramifications for THE CCG and its population. Once project plans and business cases are approved, the CYPS Programme lead will provide exception reports on an on-going basis to the CCG Programme Delivery Group during the implementation and review phases.

Programme Membership

Chair	CCG GP Clinical Lead
Clinician	GP (subject to funding being agreed)
Senior Responsible Officer	Director of Healthcare System Reform
Programme Lead	AD Integrated Commissioning & Partnerships
Programme Manager	CYPS Programme Manager
Quality	Director of Quality, Governance & Patient Safety or designate
Prescribing	Head of Medicines Management
Public Health	Consultant in Public Health
Finance	Chief Financial Officer or designate
Performance	Head of Performance or designate
LBB:	
Safeguarding Lead	AD Safeguarding & Social Care
Disabilities	Strategic Commissioner Disabilities
SEND Pathfinder	Head of SEN and Disability
Voluntary sector:	
Carers Bromley	Chief Executive
Bromley Y	Chief Executive

Members may nominate a designate who is empowered and capable to act. It is recognised that there will be linkages between the CYPS Programme and the Mental Health Programme and that both Programmes will need to ensure proactive compliance with the arrangements that are in place to address such linkages.

BROMLEY

2.7 MENTAL HEALTH STRATEGIC PROGRAMME

2013-16

1. Profile

Mental health is one of six strategic programmes that will form the vehicles for the delivery of Bromley Clinical Commissioning Group's strategic objectives over the next three years. Mental health is of critical importance in ensuring that people maintain good health and wellbeing. Given that mental health issues affect one in three people at any one time it is imperative that this strategic programme focuses on ensuring that local priorities for meeting the needs of the population in terms of mental health are acted upon and delivered.

The Integrated Commissioning Plan 2012-15 pointed to a number of recent key developments in mental health services in Bromley notably the development of an acute Psychiatric Liaison Service based in Emergency Department and on General Medical Wards. This ensures early intervention for a patient who may present with a mental health problem or a patient who has a diagnosis of dementia who is in a general medical ward who can be discharged rapidly to a more appropriate service or be cared for at home. Another development has been the expansion of the Memory Services which is focus on the older people's population with a view to increasing access to memory services for diagnosis of dementia and support with this condition. Finally there has also been the development and expansion of the Bromley Working for Wellbeing Service (the local name given to IAPT) to move towards the national objective of meeting the needs of 15% of those with moderate mental health conditions.

The Mental Health Strategic Programme will focus on five key areas;

- **Mental Health & Wellbeing**
- **Primary Care Mental Health**
- **Secondary Care Mental Health for Working Age Adults**
- **Mental Health for Older Adults**

Current Programme Budget

The current programme budget for mental health commissioning 2012/13 is £46.1 million and this commissions a range of NHS and Non NHS providers to deliver health and social care for the borough of Bromley and its residents. The impact on this budget of national policy directives around efficiencies over the next three years is an expected annual average reduction by 1.2% in the baseline planning assumptions up until 2016. This would have the overall impact of reducing the current budget by approximately £1.66 million across all commissioned services. Changes to the current mental health landscape and what is delivered locally would be required to release this efficiency. We will need to work with providers to shift and re-profile delivery into what will be most effective for the population of Bromley.

The table below outlines the main programme areas for mental health commissioned services and the associated financial allocation and the way in which the activity is contracted.

Programme Budget Forecast Outturn 2012-13:

Commissioned Area	Current Contracting Arrangement	Forecast Outturn £ 000's
High Secure Psychiatric[7]	London Specialist Commissioning Group from 13/14	£1,223
SW London & St Georges Specialist Services for the Deaf	Block Contract	£24
Specialist Psychotherapies – Tavistock & Portman	Block with Counsellors/LES arrangements	£12
Primary Care Counselling	Block Contract linked to meeting 15% of need locally	£330
IAPT	Block Contract	£1,783
MH older People		£135
Oxleas Mental Health Contract- Acute & Community Services for working age adults, older people, children & young people, and secure and forensic services[8]	Block Contract with Oxleas NHS Trust	£34,093
Community Learning Disability Team for the provision of specialist healthcare service to people with learning disability.	Block Contract with Oxleas NHS Trust	£1,671
South London & Maudsley[9]- Tertiary Services covering Tier 4 CAMHS, Eating disorders, Neuropsychiatry, ADHS assessment, Autism assessment	Cost and volume contract	£2,962
Oxleas Clinical Audit	Grant Payment	£45
MH Commissioning	Joint funding of commissioning post in LBB	£42
Community Options – Residential Provider	Block Contract for the provision of residential accommodation with Voluntary Sector Provider	£1,435
MH Cost Per Case	Cost & Volume arrangements and delegated to Oxleas and risk share arrangements in place.	£1,747

[7] This budget transfers to Specialised Commissioning Group, NCB from April 2013
[8] £2.2 million transfers from this budget for secure and forensic services to Specialised Commissioning Group, NCB from April 2013
[9] £1.6 million transfers from this budget for children to Specialised Commissioning Group, NCB from April 2013

MIND	Preventative mental health services provided in Block Contract	£98
CAMHS CPC	Specialist Placements for children and young people	£419
MH Advocacy (Rethink)	Block Contract	£63
Serious Untoward Incidents (Community Options)	Grant Payment	£65
Total		**£46,147**

2. Health Needs

Mental health/psychological symptoms are common in the adult population affecting up to 1 in 3 people. Applied to Bromley, this prevalence would mean that 64,000 people are suffering from one of these symptoms at any one time. About half of those with symptoms, 1 in 6, will suffer from a recognised mental health problem including depression, phobias, obsessive compulsive disorder, panic disorder, generalised anxiety disorder and mixed anxiety and depressive disorder. In Bromley this would equate to about 32,000 people, of whom about 4,000 people will be known to secondary mental health services. (1)

Figure 1: Main areas of mental health need in Bromley

Mental Health – 18 – 64 years	2010	2011	2012	2013	2014
People aged 18-64 predicted to have a common mental disorder	31,112	31,337	31,441	31,595	31,835
People aged 18-64 predicted to have a borderline personality disorder	872	878	881	886	893
People aged 18-64 predicted to have an antisocial personality disorder	660	665	666	670	674
People aged 18-64 predicted to have psychotic disorder	774	779	782	786	792
People aged 18-64 predicted to have two or more psychiatric disorders	13,847	13,947	13,991	14,063	14,165

Based upon Adult Psychiatric Morbidity in England, 2007 (does not include people in secondary care) and ONS data

In terms of **Older Peoples mental health** and wellbeing we know that we have a larger number of older people compared to the London Average and it is projected that we will continue to do so. Given the high numbers of older people in the population we would have expected that demand for Memory Services would be high; this assumption has been borne out and demand has grown year on year for assessment and access to Memory Services.

Figure 2 Predicted estimates of dementia in older people

Age	2011	2015
65 – 69	174	202
70 – 74	312	331
75 – 79	601	618
80 – 85	1,022	1,022
85 - 89	1,050	1,144
90+	899	1,016
Total	4,058	4,333

3. Strategic Context

The London Case for Change in Mental Health:

The London Case for Change in Mental Health Services focused on the need to improve the interface between primary care and secondary care services provided by mental health Trusts. In Bromley there has been an emphasis on developing the interface relationship between mental health and general practice and there is a joint effort between the LMC and Oxleas NHS Foundation Trust to do this in order to reduce the reliance on secondary care mental health services.

No Health without Mental Health:

The coalition government published the document 'No Health Without Mental Health' and the six core elements in this document will form the basis and rationale for the delivery of local commissioning intentions or mental health services. The six core elements are:

-

- more people will have good mental health,
- more people with mental health problems will recover,
- more people with mental health problems will have good physical health,
- more people will have a positive experience of care and support,
- fewer people will suffer avoidable harm and
- fewer people will experience stigma and discrimination.

These high level aims will form part of the key work streams that will be set within our strategic programme, QIPP schemes and commissioning intentions.

Trust Special Administrator

The TSA for South London Healthcare NHS Trust recommended proposals for the future of Queen Mary's Hospital. It is recommended that the site should be owned and run by Oxleas NHS Foundation Trust, providing the services that commissioners have identified as being required for the local population and creating a centre of excellence for inpatient mental health services across Bexley and Bromley. This recommendation, if taken forward will have significant implications for the planning and delivery of inpatient mental health services for Bromley which needs to be addressed in our strategic plan.

Mental Health Payment by Results

The implementation of Payment by Results for Mental Health from 2014/15 will have a significant impact on the commissioning framework for Mental Health Services. Care will be commissioned on the basis of Care Packages associated with 'clusters' of identified need, rather than specified services. The development and implementation of PbR will result in the need to strategically change the way in which mental health services are commissioned. Attention will need to be given to the financial implications of these changes along with the need to review some clinical care pathways for mental health services alongside the other strategic programmes in Bromley, especially primary care and long term conditions.

The National Operating Framework for 2013-14 sets out a number of key requirements for priority planning and these are:

- The NHS CB Mandate re-states the continuing commitment to putting mental health on a par with physical health

- Achievement of Quality Innovation Productivity and Prevention (QIPP) monitored against the mental health Performance

- Framework covering new cases of psychosis served by Early Implementation Trusts (EIT), gate-keeping of acute admissions by crisis teams, 7-day post discharge follow up for those on Care Programme Approach (CPA);

- Elimination of mixed sex accommodation; (achieved)

- Commissioning of liaison mental health services for general acute wards including those that provide dementia care and A&E. (achieved)

- Full rollout of access to primary care psychological therapies by 2014/15. Meet 15% prevalence (5043 patients per year in Bromley) with recovery rate of at least 50% in all services

High Impact Innovations:

Support for Carers of people with Dementia:

- We are committed to the High Impact Innovation around working with carers and ensuring that their needs are assessed and recommendations from these assessments are acted upon.
- We will work in partnership with the local council to deliver support in the form of advice, signposting and short breaks for those carers assessed as needing this level of intervention.

In Bromley, we will focus on the 4 strategic areas mentioned earlier in this paper, ensuring that the programme of work will along the strategic context as detailed in the following strategic programme delivery table,

. 4. Delivery Table

Mental Health Strategic Programme 2013-16															How Success will be Measured	National / Local Outcomes Indicators Operating Framework 2013-14	High Impact Innovations	Project Value £ 000's
Scope : Design : Procure : Implement : Review			2013-14				2014-15				2015-16							
Strategic Objective Number	MH Priority	Project	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4				
	Primary Care Mental Health	Work to address net effect of PbR changes on whole mental health system	S	S	D	P	P	I	I						20% of service users discharged from Oxleas	2.5, 5A		£0
		IAPT services to meet national 15% of need target	I			R	I								Prevent long term mental health illness	2.6, 4.8		-£626
		Develop Autism Service provision	I			R			P	P	I				Reduced Health Inequalities	2.1, 2.2		-£73
	Oxleas	Rebase Oxleas Contract	S	R	R	R	I								Value for Money			£1,050

		Develop and inpatient service on QMS site	S	S	S	D	D	I	I						Centre of Excellence	4.7, 5.3		£0
	Adult Mental Health	Re-profile & Review the Complex Needs and Recovery Services	S	S	D	I	I								Reduced numbers using CMHT's	4.7		£0
	Older Peoples Mental Health	Review and rebase Inpatient Activity	S	S			I								Development of community based services	5.1, 5.3		£0
		Review Memory Service demand and capacity	S	S	S	D									Increase diagnosis and early intervention	2.7, 2.1, 2.2, 2.3i, 2.5	Support for carers with people with dementia	£0
Total																		**£351**

5. QIPP Plan

						FULL SAVINGS (NET)		
Scheme	Description	Strategic Programme	Area of spend	R/NR	2012/13 Forecast outturn	2013/14 Plan	2014/15 Plan	2015/16 Plan
					£'000	£'000	£'000	£'000
Brought Forward Schemes								
New Schemes (Firm)								
IAPT Expansion	To meet 15% of local need	Mental Health		R	-£1,783	-£313	-£313	£0
	fye (2,121,047)	(PYE +313K)						
Autism Assessment Service	Stepped Service Model ASD Assess	Mental health			£0	-£33	£0	-£40
New Schemes (In Development)								
Rebase Bed Activity	Review Current Bed Usage OPMH & WAA	Mental health		R	£0	£150	£450	£450
Total					**-£1,783**	**-£196**	**£137**	**£410**

6. Governance

Governance & Decision Making Arrangements:
The Mental Health Programme underwent a rigorous process of approval in line with the CCG's governance structure and will be submitted to the Governing Body for approval at its first meeting on 18th April 2013. Following that, the Mental Health Programme Group will initially scope and design the approved list of projects set out in the delivery table. As stated, in some instances the projects represent work that is already underway and will be carried forward. The Programme Group will ensure delivery of any proposed QIPP savings, consider quality, clinical effectiveness, and value for money to work up project plans and business cases for each project. The Mental Health Programme lead will present project plans and business cases to the Strategic Planning Group to seek its onward recommendation. The Strategic Planning Group will consider their strategic fit with the programme that has been approved and make recommendations to the Clinical Executive for approval. In some instances, the Clinical Executive will recommend to the Governing Body for decision. This is relevant for example when section 256 funding is required for release or where the size and scale of the project has significant ramifications for the CCG and its population. Once project plans and business cases are approved, the Mental Health Programme lead will provide exception reports on an ongoing basis to the CCG Programme Delivery Group during the implementation and review phases.

Programme Group Membership

Chair	GP Clinical Lead
Clinical Leads	1 further GP
Programme Lead	Associate Director of Integrated Commissioning & Partnerships
Programme Sponsor	Director of Healthcare System Reform
CCG Commissioning Support	Senior Commissioning Manager
CCG Commissioning	Interim Programme Manager
LBB	Strategic Commissioner
Patient rep	Mental health service user
Public Health	Senior Public Health Consultant
Finance Rep	Chief Financial Officer or designate
Information	Head of Performance or designate

Members may nominate a designate who is empowered and capable to act. It is recognised that there will be linkages between the CYPS Programme and the Mental Health Programme and that both Programmes will need to ensure proactive compliance with the arrangements that are in place to address such linkages.
There are a number of other governance and partnership arrangements in mental health that shape and oversee strategic programme decisions. These are outlined below:

- **Mental Health Executive** - a Joint Commissioning Board that is chaired by the CCG Accountable Officer, and has representatives from the CCG, the London Borough of Bromley, GP Clinical Leads and an Oxleas Non Executive Director. This board has an oversight role and has an agreed plan in relation to the delivery of mental health commissioning and service delivery.

- **Mental Health Partnership Group** – this is a representative group of providers from NHS and non NHS organisations, voluntary sector, service users, carers, commissioners, local authority representation, police and other partners who may be invited. This group has a role in the shaping of services and undertakes various pieces of work in terms of the quality and delivery of services with a view to improving the overall experience of service users and carers.

The Programme Group, The Mental Health Executive and the Partnership Group will work in an integrated fashion to agree and ensure the delivery of the mental health programme. This may require adjustments to the way in which the groups work. In terms of the London Borough of Bromley where there are areas of work that may impact jointly this will be taken through their governance and decision making process.

2.8 Developing the Delivery Plan - Key National Influences 2013-14

NHS Operating Framework

2013-14 represents the first year that the NHS Operating Framework has been written for the new NHS architecture built around clinical commissioning groups who have 'assumed liberty' for local commissioning. The NHS Operating Framework for 2013-14 'Everyone Counts: Planning for Patients' sets out its expectations that Clinical Commissioning Groups will be held to account by the NHS Commissioning Board to perform to the standards of the NHS Mandate.

The Mandate was published in November 2012 and comprises:

- A refreshed NHS Outcomes Framework
- NHS Constitution

The Operating Framework is mindful that the NHS is facing unprecedented challenges of an ageing population, greater demand and limited resource growth. These challenges mean that all NHS organisations need to play their part in improving services for patients to secure better value from every pound spent on the NHS.

NHS Outcomes Framework

The NHS Outcomes Framework was first published in December 2010, and has been updated annually. Its focus shifts commissioners away from targets and onto patient outcomes. Its purpose is threefold:

- To provide a national level overview of how well the NHS is performing
- To provide an accountability mechanism between the Secretary of State for Health and the NHS Commissioning Board
- To act as a catalyst for driving quality improvement and outcome measurement throughout the NHS by encouraging a change in culture and behaviour, including a stronger focus on tackling health inequalities

The NHS Outcomes Framework is structured around five domains, which set out the high level national outcomes that the NHS should be aiming to achieve. They focus on:

- Preventing people from dying prematurely
- Enhancing quality of life for people with long term conditions
- Helping people to recover from episodes of ill health or following injury
- Ensuring that people have a positive experience of care
- Treating and caring for people in a safe environment; and protecting them from avoidable harm

These five domains cover twenty seven improvement areas which have been allocated to the CCGs Strategic Programmes as the local vehicles for achieving them.

2.9 Medium Term Financial Plan

Financial Context

Commissioners in Bromley have a strong track record of financial delivery having consistently met all statutory financial targets, as shown in Table 1 below:

Table 1: Statutory Financial Targets	2010/11 £000	2011/12 £000	2012/13 £000
Net Operating Cost	505,648	514,243	535,543
Revenue Resource Limit (RRL)	512,547	520,354	540,563
Under/(Over)spend against RRL	6,899	6,111	5,020

Source: PCT Annual Accounts. The 12/13 position is the forecast based upon Month 11 as the final position will not be confirmed until the 12/13 accounts have been submitted on the 22nd April 2013 and are signed off by the auditors.

From April 2013, the responsibility for commissioning services for the population of Bromley will be with the Bromley Clinical Commissioning Group following shadow running of all budgets for the full 2012/13 financial year. The CCG / PCT met its obligations in 2012/13 including a £5.2m surplus and will achieve its QIPP plan savings of £9.2m. The CCG therefore inherits a position in recurrent balance. Underlying the 2012/13 position was a significant non-recurrent benefit in relation to the cap and collar arrangement with South London Healthcare which was offset by the requirement to establish a provision for the costs of un-assessed periods of continuing care.

This section summarises the medium term financial strategy (MTFS), which underpins the Integrated Commissioning Plan 2013/16 and will support the CCG towards its vision and objectives for the next 3 years.

The CCG's allocation for 2013/14 is £369m. The statutory financial duties of the CCG are:

- Stay within its revenue and capital resource limits in any one year
- Stay within its cash limit in any one year

In addition to these duties, the NHS Operating Framework also requires that:

- No CCG should plan for a deficit in 2013/14 – for the CCG's operating plan going forward, a 1% surplus control total has been planned for, increasing to 2% in 2014/15.
- CCG to identify 2% of its allocation for non-recurrent expenditure purposes only
- Set aside 0.5% of it's allocation as a contingency reserve.
- Plan for a QIPP savings of 2% plus 50% contingency against non-delivery of schemes (£10.5m)
- Running costs of £25 per head of patient population (the CCG has contracted with the CSU for £8 per head of this envelope)

Within this context, the CCG Medium Term Financial Strategy aims to:

- Ensure that the CCG is financially stable and meets its duties as set out above

- Support the vision and objectives of the CCG, underpinning the 3 year Integrated Plan
- Support the CCG QIPP (Quality, Innovation, Productivity and Prevention) Plan required to ensure continued financial viability as well as working towards a financially sustainable health economy.
- Identify the risks and the resource requirement of the CCG over the medium term and ensuring these are accounted for in the development of the strategy

Financial Strategy

The CCG has set out its financial strategy for the next three years from 2013/14 to 2015/16. This has been developed in conjunction with the overall Integrated Plan.
The plan has been developed based on National and NHS Commissioning Board London guidance and assumptions, as well as local factors and QIPP savings plans.

Table 2 below sets out the changes to income and expenditure over the three year period.

Table 2: Income and Expenditure	**2013/14**	**2014/15**	**2015/16**		**Total 2013/14 - 2015/16**
	£'000	£'000	£'000		£'000
Income					
Recurrent Uplift	8,301	3,692	3,729		15,722
Prior Year Surplus brought forward	3,653	3,691	7,459		14,803
Total Income Changes	**11,954**	**7,383**	**11,188**		**30,525**
Expenditure					
Net Generic Uplifts					
Tariff and generic uplifts	7,206	8,530	8,545		24,281
Efficiency with Tariff	-10,661	-12,637	-12,659		-35,957
Net Tariff/ Generic Uplift	-3,455	-4,107	-4,114		-11,676
Demographic & Non-Demographic Growth					
Demographic Growth	2,003	1,653	1,655		5,311
Non-demographic growth	8,038	6,236	6,248		20,522
Total Demographic & Non-Demographic Growth	10,041	7,889	7,903		25,833
Investment Proposals and cost pressures	11,907	6,642	10,366		28,915
QIPP Savings Initiatives	-10,500	-10,500	-10,500		-31,500
		¤			
Change in Recurrent Expenditure	**7,993**	**-76**	**3,655**		**11,572**
Surplus/ (Deficit)	**3,691**	**7,459**	**7,533**		**18,953**
Planned surplus as % of Recurrent RRL	**1%**	**2%**	**2%**		

The 3-year plan sets out how resources received are used in Bromley to support CCG strategic aims and objectives, whilst ensuring that resources for growth and cost pressures are set aside. It also identifies QIPP savings required in order for commissioners to ensure that its financial duties and targets are met and that financial viability is maintained. It should be noted that from 2014/15 the CCG will be required to achieve a 2% surplus each year.

Table 3, below sets out the key uplift assumptions used by the CCG in developing its three year plan.

Table 3: Key Uplift Assumptions	**2013/14**	**2014/15**	**2015/16**
Revenue Resource Limit (RRL) Recurrent uplift	2.30%	1.00%	1.00%
Demographic Growth	0.63%	0.53%	0.53%
Non-demographic growth	2.00%	2.00%	2.00%
Total population & incidence growth	**2.63%**	**2.53%**	**2.53%**
Prescribing growth	4.00%	4.00%	4.00%
Tariff/ Inflation Uplift	2.70%	2.70%	2.70%
Tariff efficiency assumption/ Price Efficiency applied	-4.00%	-4.00%	-4.00%
Net Tariff/ Inflation Uplift	**-1.30%**	**-1.30%**	**-1.30%**

Details of future revenue resource limit increases, the impact of any revised capitaion formula or tariff changes from 2014/15 are yet to be announced. Bromley CCG has assumed an increase of 1%, with the tariff deflator remaining the same from 2014/15.

Fundamental to the delivery of CCG financial targets is the QIPP programme, which focuses on driving efficiencies in providers, optimising spend and delivering quality and shifting care into the most cost effective settings.

Table 4 below, sets out an overview of the CCG QIPP programme over the three years, both before and after adjusting for risk.

Table 4: QIPP Overview	NET SAVINGS			GROSS SAVINGS		
	2013/14 Plan	2014/15 Plan	2015/16 Plan	2013/14 Plan	2014/15 Plan	2015/16 Plan
	£'000	£'000	£'000	£'000	£'000	£'000
Acute	5,352	7,368	9,109	6,121	8,570	9,109
Client groups / Non-Acute	4,045	911	0	4,045	917	0
Primary Care (exc. Presc.)	103	1,221	391	103	1,221	391
Prescribing	1,000	1,000	1,000	1,000	1,000	1,000
Other Budgets and Reserves	0	0	0	0	0	0
Total	**10,500**	**10,500**	**10,500**	**11,269**	**11,708**	**10,500**

Financial Risks

The CCG faces a number of risks and challenges over the next 3 years which will need to be monitored closely through the organisations risk assurance framework and integrated governance arrangements.

Table 5 below outlines the most significant financial risks that may arise.

Table 5: Financial Risks

Risk	Description	Likelihood	Value	Mitigation
Impact of recommendations arising from the TSA report	TSA recommendations will impact on SEL CCGs and therefore particular contingencies are required. The particular risks could be described as: • Cost of implementation of Community Based Care strategy • Delay in implementation of Community Based Care Strategy / on too small a scale • Overspend on acute contracts due to lifting of cap and collar arrangement and transfer to running by King's	High	High	• Set aside 0.5% of RRL in 13/14 as a general contingency to support risk • Commit 1% non-recurrent to fund implementation of CBC strategy • Set aside further 0.5% to support transformational QIPP related to CBC strategy
Resource allocation	Allocation may not be correct or sufficient to cover commitments if impact of commissioning decisions by NCB and SCG are not fully understood	High	High	Monitoring arrangements by NCB in place across whole system including regular three-way communication of decisions and their likely impact
Acute over-performance	Potential over-performance across all acute contracts	High	High	Final acute contracts have not yet been agreed. Robust working with CSU, providers and other South London CCGs. Direct involvement of clinical

				commissioners. Appropriate contingencies set.
New PbR tariff	Impact of new tariff may not be fully understood	High	High	Continued modelling and understanding of the impact
Continuing care	Ongoing risk around unassessed periods of continuing care	High	Medium	Ongoing review, time limited risk has been quantified
Prescribing / impact of new treatments	Impact of new drugs on prescribing budgets in particular anti-coagulation	High	High	Increased uplift provided, but close monitoring required. Impact of new treatments to be separately modelled
Non-acute over-performance	Overspends in other commissioned services including mental health and continuing care	Medium	Medium	Historically has been well managed within budget, but risks around mental health cost per case
Running Costs	Inadequate budgets for reasons such as additional responsibilities not anticipated; service model needs to be reviewed; CSU cost pressures.	Medium	Low	Budgets within £25 per head ceiling. To be closely monitored and reviewed compared with outcomes. CSU contract set at £8 per head, to be managed
Fair share	Return of fair share of PCT 2012/13 surpluses	Medium	Medium	SEL CCGs plan to deliver a 1% surplus in 2013/14

In addition to the 0.5% contingency, the CCG has agreed a framework for managing risk with the other 5 CCGs in South East London.

The SEL CCGs have a track record of collaboration and successful risk management across the health economy. A formal framework for collaboration has been agreed in 2012 and submitted by all CCGs as part of authorisation evidence.

The principles of collaboration and risk management across all SEL CCGs centre around CCGs collaborating to improve outcomes, quality and VFM through addressing transformational change across multiple boroughs and securing long term sustainability for SEL CCGs and commissioned health services. Risk management plans include risk sharing with providers, risk sharing across commissioners and mutual financial assistance between SEL CCGs to support delivery of individual CCG financial targets in the short term, assist recovery and sustain ongoing strategic direction without destabilising the health economy.

Governance arrangements underline accountability at local CCG level and bring CCGs together to make collective decisions on and take oversight of SEL wide transformational strategy (such as the community based care strategy), risk management and other health economy wide priorities.

8.3 Demand and activity assumptions

Commissioners in Bromley have a strong track record of working closely with its main providers on assumptions for demand and activity planning. This robust and established demand planning process helps to support the negotiation and agreement of contracts. It ensures that activity and financial assumptions and plans are closely aligned not only with each other but also with those of the providers.

We have a co-ordinated approach, ensuring that finance and activity are in alignment. This ensures that agreed contracts reflect Bromley's commissioning intentions, and that the financial implications of the agreed contracts are reflected in the CCG's budgets.

The approach used to inform the 2013/14 contracting round for acute, community and mental health providers is set out below.

Acute Contracts

For the 2013/14 contracting round the CCG contracted with the South London Commissioning Support Unit to lead the work around demand and activity assumptions which underpinned contract negotiations on behalf of the CCG. Generally, activity plans are based on predicted outturn for 2012-13, with adjustments for the impact of known QIPP schemes and changes in commissioning requirements. However, for SLHT the quality of activity data remains a factor in gauging the reliance that can be placed on planning forecasts. Of particular significance in the contracting round this year is the future intention for King's College London to assume running of the Princess Royal University Hospital. The approach to this has been to continue to negotiate with SLHT based on their knowledge of the current running of the hospital, its associated capacity and activity, a position that both the CCG and KCL can agree to take forward.

Community

Bromley Healthcare is the main provider of community services for the population of Bromley. The contract of £35m is cost and volume, with a threshold before activity changes activate additional payment. The contract is for five years, during which all services will be reviewed to test their value for money and effectiveness, leading to service redesign, or potentially tendering of the service. Current tender plans include Intermediate Care services and the Urgent Care Centre at the PRUH. Services for Diabetes and Rapid Response/Step Up services are also subject to redesign. Bromley Healthcare is also actively engaged in the ProMISE programme, through the development of integrated teams to support groups of GP practices with the management of patients with long term conditions.

The local community provider market has strengthened through increased experience of Lewisham Healthcare and Oxleas, and growing interest from private and voluntary sector providers. This will be significant as the CCG rolls out the Community Based Care strategy which underpins the SLHT Trust Special Administrator recommendations.

Mental Health

The main provider of mental health services to Bromley is Oxleas Foundation Trust, and most of the contract is currently block, with some risk share agreements around individual high cost patients. Activity is monitored in year, and this informs step changes in the commissioning of capacity for the following year. At present capacity is commissioned rather than activity. For example monitoring inpatient activity in a service where there is a planned shift in activity from inpatient to community base may trigger a reduction in the number of beds purchased. An

increase in the waiting list, or time waited for an outpatient service may trigger increased investment in the capacity to deliver that service.

However, during the current financial year Oxleas will be moving towards a Payment By Results approach. The CCG is working closely with Oxleas to ensure a shared understanding of the implications of this, in terms of shared information and planning, but also in terms of the potential for changes in the admission, discharge and patient management dynamics.

2013 – 2016 QIPP Plan

The QIPP programme for this year is challenging at £10.5m, and is mainly predicated upon our ability to make pathway changes through activity shifts out of secondary care, moving care into the community where appropriate. Working with King's College London to ensure effective management of our main acute contract as they become the provider for the Princess Royal University Hospital site in this financial year will be one of our main priorities.

We have, in addition, identified a number of new initiatives which will deliver improvements in clinical quality across a range of pathways, along with improved efficiency, shifting care closer to home for many patients. Our aim is to lay the ground work during this financial year to enable us to deliver the Community Based Care Strategy over the next 3 years at scale and pace in keeping with the TSA's recommendation.

Our Planned Care and ProMISE programmes are, in particular, designed to deliver this shift enabled by expanded primary care capacity and capability and an Unscheduled Care programme to prevent unnecessary admissions to hospital. Each programme is supported by a set of QIPP schemes designed to contribute toward shifting care out of hospital.

Our largest Planned Care schemes are redesign of cardiology pathways to deliver £788k in its first full year and anti-coagulation to deliver £775k. Re-procurement and reconfiguration of urgent care centres at the PRUH and Beckenham Beacon sites is expected to realise in excess of £2m in savings in their first year. The urgent care centre at the PRUH has already been successful in diverting 38% of activity away from A&E and full year effect of the new provider is expected to increase this to 50%. In our strategic programmes we have described longer term measures too which will be developed during 2013-14 for delivery of QIPP savings in years 2 and 3. Included in this is our high profile ProMISE programme partly funded through section 256 monies in collaboration with the London Borough of Bromley. The ProMISE programme focuses on developing proactive services for the elderly to work in an integrated way across the whole system. Working closely together with Unscheduled Care programme leads, a redesigned integrated care pathway including rapid response and assessment step up and step down capabilities is expected to deliver nearly £3m over the next 3 years.

						FULL SAVINGS (NET)			FULL SAVINGS (GROSS)		
Scheme	Description		Area of spend	R/NR	2012/13 Forecast outturn	2013/14 Plan	2014/15 Plan	2015/16 Plan	2013/14 Plan	2014/15 Plan	2015/16 Plan
		Strategic Programme			£'000	£'000	£'000	£'000	£'000	£'000	£'000
Schemes Completed in 2012-13					(11,459)	0	0	0	0	0	0
Anti Coagulation (BBG)	This scheme reflects the full year effect of the reprocured anti coagulation scheme, which has been delayed this year, and will have a lower impact than expected in 2012-13, but a greater impact in 2013-14.	Planned Care	Acute	R	255	517	258	0	1,178	589	0
Gynaecology	Full year effect of delivery of existing scheme	Planned Care	Acute	R	102	425	0	0	641	0	0
Dermatology	Full year effect of delivery of existing scheme	Planned Care	Acute	R	164	363	0	0	588	0	0
Urgent Care Centre (PRUH) increased throughput	The delivery of this scheme has been slower than anticipated in 2012-13, although the rate of UCC activity now appears to be increasing. The full year effect of running at 50% UCC activity will apply in 2013-14	Unscheduled Care	client groups	R	525	525	0	0	525	0	0
Bereavement Counselling	Full year effect of delivery of existing scheme	Unscheduled Care	client groups	R	50	50	0	0	50	0	0

Prescribing efficiency	Existing QIPP plan	Primary Care	Primary Care	R	1,118	1,000	1,000	1,000	1,000	1,000	1,000
UCC (PRUH) Procurement	This scheme relates to the procurement of a new UCC provider and the efficiences gained from the process once the service is re-provsioned	Unscheduled Care	client groups	R		750	250	0	750	250	0
Cardiology Pathways	Redesigned cardiology pathway bringing more outpatient activity into the community, will have a partial effect in 2013-14.	Planned Care	Acute	R		331	331	0	953	953	0
Cardiology Pathways	Redesigned cardiology pathway bringing more outpatient activity into the community, will have a partial effect in 2013-14.	Planned Care	Acute	R		361	361	0	361	361	0
Intermediate Care Procurement	Procurement post Orpington consultation, part year effect	Unscheduled Care	client groups	R		300	300	0	300	300	0

Continuing Care AQP tariffs	London wide AQP process	Unscheduled Care	client groups	R		200	0	0	200	0	0
Elmstead decommissioning	Bromley CCG does not wish to commission services at Elmstead. Revisions to the pathway are already in place and should halt the overspend in 2012-13, there should be no planned activity in 2013-14.	Unscheduled Care	Acute	R		300	0	0	300	0	0
Diabetes in Primary Care	The revised diabetes model for BBG will rationalise tier 4 services which are currently split between Kings and SLHT, to one provider.	Planned Care	Primary Care	R		103	361	391	103	361	391
Long Term Conditions - Falls	A fall service is under discussion with BHC which will have an impact on emergency admissions	ProMISE	Acute	R		103	118	27	103	459	482
Rapid Response and Assessment	we will redesign the Rapid Response and Assessment service provided by BHC, to include greater Step Up capability, with impact on emergency admissions in 2013-14	Unscheduled Care	Acute	R		500	1,000	0	500	1,000	0

Long Term Conditions - Self Care	We will extend the work we currently do with long term conditions patients, eg COPD on self care regimes to avoid emergency admissions	ProMISE	Acute	R		0	0	0	0	0	0
Long Term Conditions - End of Life Care	We are planning to work with St Christopher's Hospice to ensure greater coordination of end of life care pathways, and ensure that more patients are able to die at home if they wish	ProMISE	client groups	R		43	29	0	43	29	0
Long Term Conditions - Integrated Care Teams	The outcome of the first phase of the ProMISE research work will enable us to reshape our integrated care teams to focus on those patients who are most likely to benefit from intervention, as an alternative to hospital admission	ProMISE	Acute	R		180	119	1,455	180	1,232	2,552
Gastroenterology Pathways	Re specify pathways with existing providers to meet NICE guidelines and reduce referrals	Planned Care	Acute	R		100	0	0	100	0	0

Planned Care/Diagnostic Centre (ENT/Urology/Neurology)	This is likely to be an extensive piece of work in the light of the TSA process, focusing greater levels of ambulatory activity in primary care and the community. We have made a prudent assumption of the impact in 2013-14	Planned Care	Acute	R		0	933	1,333	0	2,800	4,000
Telephone clinical Advice	To focus on fracture patients at A&E to be discharged with advice and follow up telephone contact as an alternative to a fracture clinic appointment	Planned Care	Acute	R		70	70	0	80	80	0
Patient Transport Management (BBG)	We are dissatisfied with the SLHT contract management role for the Savoy patient transport contract. We will wish to reprocure this element of the work.	Planned Care	client groups	R		100	200	0	100	200	0
Patient Transport Management (BBG)	Effective management of the PTS contract	Planned Care	client groups	R		400	0	0	400	0	0
Orpington Centre - Design of Services	per consultation business case	Planned Care	Acute	R		0	0	500	0	0	1,000

MCATs		Planned Care	client groups	R		977	32	0	908	38	0
Pathology Direct Access Procurement (BBG)	Respecify and procure direct access requirements	Planned Care	Acute	R		0	960	0	0	960	0
LES Review		Primary Care	Primary Care	R		0	860	0	0	860	0
SLHT Acute Efficiency	Performance measures re outpatient follow up; consultant to consultant referrals; Procedures of liminted clinical effectiveness etc	Planned Care	Acute	R		1,100	0	0	1,100	0	0
Beckenham UCC	Reconfiguration of current service	Unscheduled Care	Client Groups	R		500	0	0	500	0	0
Reduce UTI Admissions to Acute	Training for nursing & residential homes and domiciliary workers	ProMISE	Acute	R		107	133	0	107	136	0
Community Equipment	Reduce expenditure on Community Equipment	Unscheduled Care	Client Groups	R		200	100	0	200	100	0
Child in a Chair in a Day		Children & Young People	Client Groups	R		0	0	0	0	0	0
CYP - SEND		Children & Young People	Client Groups	R		0	0	0	0	0	0
CYP - IAPT		Children & Young People	Client Groups	R		0	0	0	0	0	0
Patient Referral Centre	Review of PRC with a view to maximising compliance and development as an information hub	Planned Care	Acute	R		0	0	0	0	0	0
GRASP (Stroke Prevention)	Roll out of GRASP risk stratification tool in all GP Practices	Planned Care	Primary Care	R		0	0	0	0	0	0

Sub Total					**9,245**	**9,604**	**7,415**	**4,706**	**11,269**	**11,708**	**9,425**
To Be Developed					**0**	**896**	**3,085**	**5,795**	**(769)**	**(1,208)**	**1,075**
Total					**9,245**	**10,500**	**10,500**	**10,500**	**10,500**	**10,500**	**10,500**

PART C
CLINICAL LEADERSHIP & GOVERNANCE

3.0 Approach to Integrated Governance and Clinical Leadership

Bromley Clinical Commissioning Group's approach to integrated governance is founded upon the principles of open, inclusive, responsible, safe and effective decision-making, ensuring that the interests of patients and the public remain central to our goals.

Our approach is characterised by having clinical leadership across all aspects of our integrated governance framework from the chairmanship of our governing body through to individual projects and schemes within our six defined strategic programmes:

i. Unscheduled Care
ii. Planned Care
iii. Primary Care
iv. Proactive Management of Integrated Services for the Elderly (ProMISE)
v. Children's, Young People's and Maternity
vi. Mental health

Our clinical leads are supported in ensuring that we meet our obligations and responsibilities as a commissioning body whilst delivering our ambitious strategic goals by our team of skilled and experienced managers and support staff. They work in partnership within a governance structure comprising a defined set of groups with clarity of purpose, appropriate levels of delegated authority, effective membership and clear responsibilities and expectations in terms of regular inputs and outputs.

The approach is designed to achieve the right balance between minimising bureaucracy to expedite decision-making but to do so with the proper levels of assurance and safety that ensure compliance with the governing principles, rules and procedures and responsibilities for probity and accountability as defined in our constitution

One key consideration is the degree of service user and stakeholder involvement within our integrated governance framework, to support the principles of openness and inclusivity that underpin all aspects of our work.

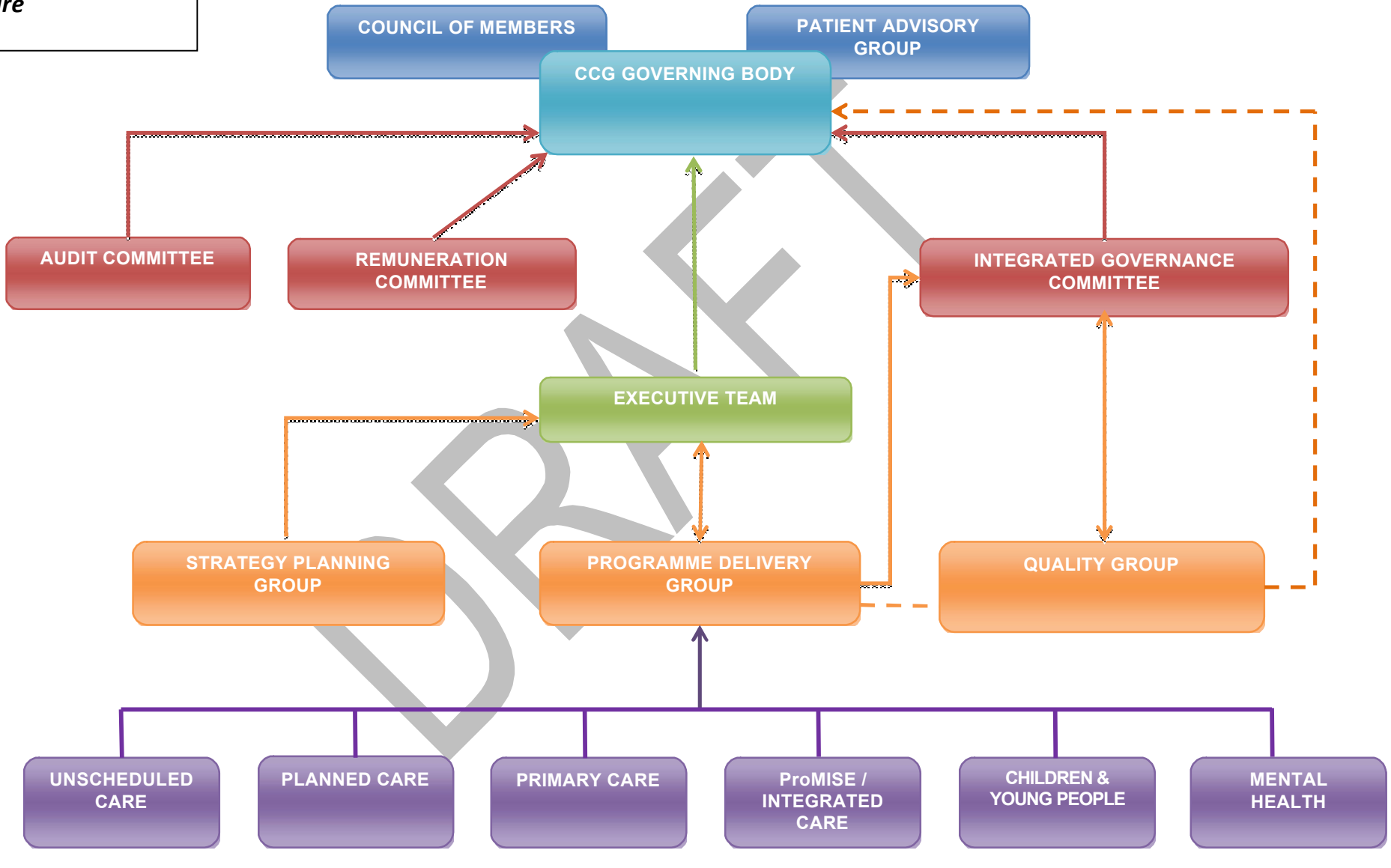
The CCG already has a strong track-record of service user and other stakeholder engagement at a programme development level. Patients, carers and other partners continue to be given the opportunity to be actively involved in helping to determine our priorities and to shape services in a way that best meets their needs, for example a local Cardiac User Group comprising cardiac patients, carers and Bromley LINk has been set up to help us review the effectiveness and accessibility of the services currently on offer and how they might be improved.

We wish to continue to broaden that engagement so that patients, carers and others are given the opportunity to be involved at all levels from contributing to service redesign through to setting our strategic direction and the assurance of our systems and processes.

The principle of a Patient Advisory Group has been established within the framework and terms of reference for this service user representative group have been developed. It is envisaged that membership of the group, which we are planning to be chaired by the lay member with responsibility for patient and public involvement, will be drawn from local patient representative organisations and patient members of the many GP practice patient participation groups now established within Bromley. This Group will provide an independent assurance overview of our work.

Integrated Governance Structure

NHS
Bromley Clinical Commissioning Group



Managing QIPP

Background

This section sets out the roles and relationships of groups and individuals in relation to the delivery of the CCG's QIPP. It refers to the proposed CCG organisational structure, contracted for CSU functions, and changes to the governance structure of the CCG which were implemented in 2012. These issues have each been discussed in the Executive and in the Local Clinical Commissioning Committee, and are now brought together to a comprehensive overview. This will enable a clearer understanding of the checks and balances built into the system to ensure that the appropriate level of focus is placed on each scheme.

This chapter defines the key roles in relation to:

- Governance
- Programme Leads
- Project support functions
- Programme Assurance

Accountability

The Clinical Commissioning Group is accountable for the delivery of its QIPP. For 2013-14 schemes across the six strategic programmes collectively are expected to deliver savings of £10.5m. The status of these schemes ranges from:

- those already completed, which are delivering benefits
- those being implemented, which require further work to capture the benefits
- those in the procurement stage
- those in the design stage

The CCG is accountable for the overall delivery of the QIPP, and therefore has put in place effective processes to hold to account all managers charged with delivering a scheme, whether internal to the organisation or not.

The Director of Healthcare Systems Reform is the lead Director for the QIPP plan and its delivery, and is responsible for ensuring coordination and management of the overall process.

The starting project plans for each of the 2013-14 QIPP schemes is used as a basis for monitoring progress against key milestones and delivery throughout the year.

Governance Structure

The Governing Body of the Clinical Commissioning Group gains assurance about its delivery against the QIPP from the Integrated Governance Committee. The Integrated Governance Committee, meeting monthly, reviews the overall financial, quality and performance position of the CCG, including the QIPP. It receives from the Head of Performance a report on overall progress against the QIPP, which has been reviewed by the Programme Delivery Group, highlighting areas of exception, and requires a briefing from Programme Leads where necessary.

The Programme Delivery Group meets monthly, and is serviced and coordinated by the Performance Manager. It has a two part agenda, one part covering the formal QIPP plan, and the other part covering the development Programmes. In the part of the agenda covering the formal QIPP plan it receives a report from the Head of Performance which shows progress against each of the QIPP schemes. The Head of Performance works with Programme Leads to ensure that individual project plans are updated and reviewed each month. By exception, project plans are reported to the Performance Delivery Group, and Programme Leads and individual project managers are required to brief the Performance Delivery Group. The Programme Delivery Group is responsible for identifying areas of risk and initiating the work required to clarify, mitigate risk and where appropriate redesign schemes. The Performance Delivery Group modifies the report of the Head of Performance for onward reporting to the Integrated Governance Committee, and to the National Commissioning Board performance team (meantime SEL Cluster).

The Strategic Planning Group meets monthly and is led by the Head of Strategy and Planning and serviced by senior administrative support. It is responsible for ensuring strategic fit, prioritising and ensuring that new schemes have been sufficiently worked up before onward recommendation, and recommending business cases for approval by the Clinical Commissioning Executive, and where appropriate for formalisation into the QIPP plan and ongoing management by the Programme Delivery Group.

Programme Leads

The Integrated Plan 2012-15 identified six strategic programmes which encompass and organise all development plans, including QIPP schemes, which the CCG has since focussed on developing for delivery over the next three years. In addition a further programme covers corporate functions. A Programme Lead has been identified for each of these programmes, and they are accountable to the Programme Delivery Group for progress against QIPP schemes, and other key developments.

The Programmes and Programme Leads are:

Unscheduled Care	Ass Dir of Integrated Commissioning and Partnerships
Planned Care	Ass Dir of Development
Primary Care	Ass Dir of Development
Long Term Conditions (ProMISE)	a director level interim has been appointed
Children, Young People and Maternity	Ass Dir of Integrated Commissioning and Partnerships
Mental Health	Ass Dir of Integrated Commissioning and Partnerships
Corporate	Chief Financial Officer

Project Support Functions

Project support will be provided to the Programme Leads through four main routes:

- project management and clinical redesign support through the Development team. The Development team will also coordinate any procurement processes outside existing contractual arrangements, whether undertaken by CCG staff or external support
- project finance support through the Finance Team
- analytical and performance measurement support from the Performance Team

- market management and provider capacity support from the Planning Team and the Integrated commissioning Team

Programme Assurance

The Performance team monitors, manages and reports on progress against the QIPP schemes, individually and collectively, to provide assurance to the Programme Delivery Group, and the Integrated Governance Committee about progress against key milestones, levels of activity and the financial implications of schemes as they are delivered. In addition, reports have been provided to the Cluster performance management regime, through bi-monthly stock take meetings. In addition, the SEL Cluster Director of Performance has been briefed in the intervening months. It is assumed that a similar regular reporting regime will be in place when the CCG is performance managed by the National Commissioning Board from April 2013.