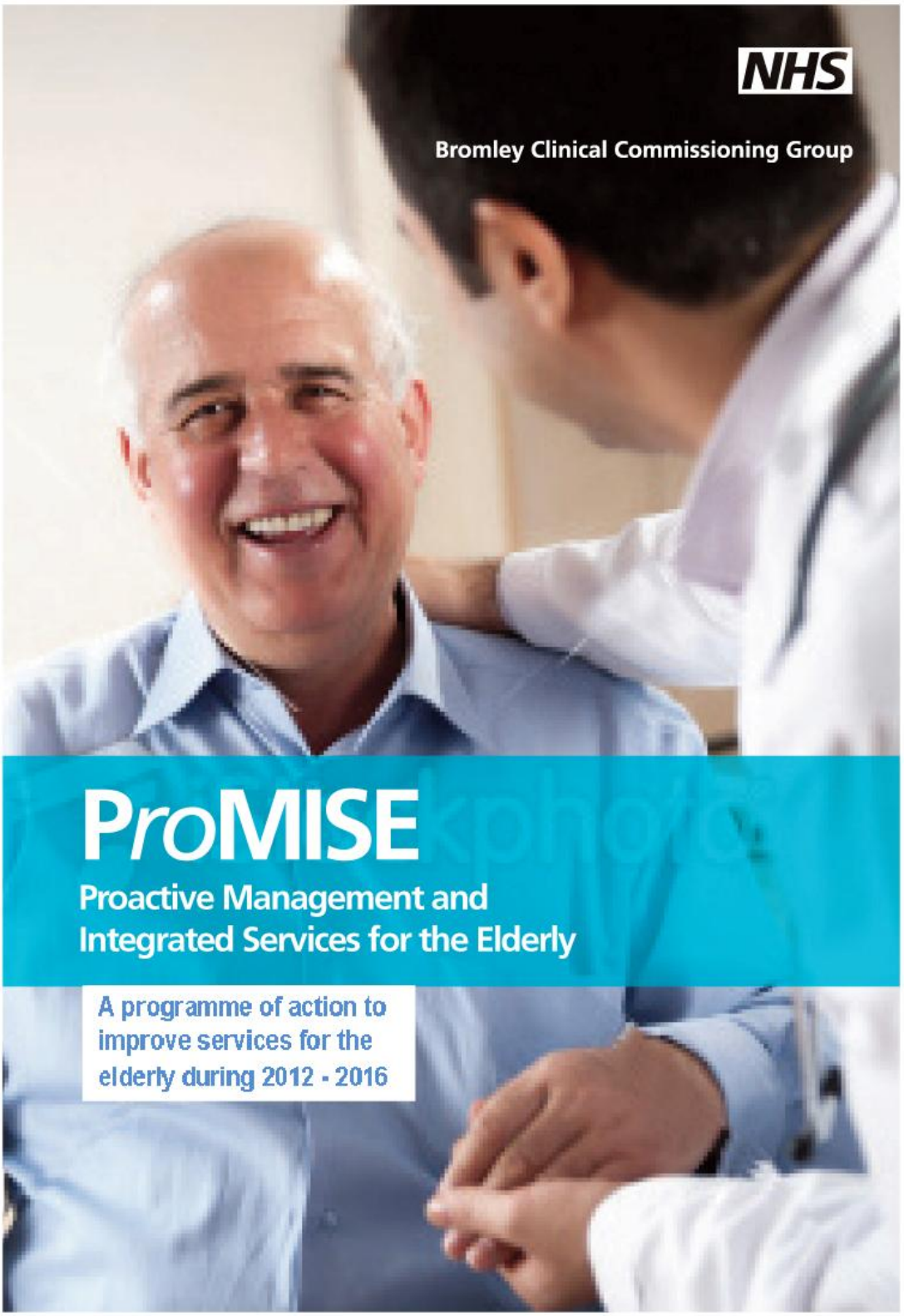

NHS
Bromley Clinical Commissioning Group
ProMISE
Proactive Management and
Integrated Services for the Elderly
A programme of action to
improve services for the
elderly during 2012 - 2016

1.0 Introduction

The aim of this programme is to ensure that older people, particularly those with a complex or long term condition will be managed within a system that identifies and responds to their individual needs, supported by a framework of integrated services that work together to better anticipate people's needs and to keep them out of hospital whenever possible.

In September 2012 the Bromley Clinical Commissioning Group (BCCG) published the second iteration of an outline programme to take forward the agenda. The projects that will be managed within the programme have now been further developed. The purpose of this paper is to:

- Brief the Bromley Health and Wellbeing Board (H&WB) on the scope of the programme and how it has evolved
- Confirm the programme's relationship with other key strategic issues such as the Trust Special Administrator's report and the associated Community Based Care Strategy for South East London and the CCG Integrated Delivery Plan 2013/14
- Describe the high level outcomes to be delivered by the Programme.
- To note that the projects will be pump-primed from section 256 funds held between BBG and London Borough of Bromley

1.1 Background

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.

1.1.1 Demographic Need

Latest demographic figures quote the Bromley registered population as 331,465[1]. The JSNA 2012 estimates a rise to 326,217 by 2017 and 332,956 by 2022. Elderly people represent 17.6% of Bromley residents (2011), equating to 54,000; the greatest concentration of elderly in London. It is expected that this will increase to 57,000 (an increase of 5%) by 2015 and will continue to increase to 74,100 (37%) by 2030. With residents living longer, greater pressure is being put on the system. As demonstrated in the JSNA, the implications of this are:

- Increased demand on healthcare & increased costs
- Increased demand on social care & increased costs
- A greater number of complex packages required from multiple agencies, which is likely to increase costs on already constrained budgets

The key disease challenges for the area are heart disease, diabetes, respiratory disease and dementia.

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

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

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

Due to the complexity and extent of co-morbidities in older people, this cohort are understandably high users of services, regularly accessing GP practices, hospitals, clinics, social services, community care and pharmacies.

1.1.2 Financial Expenditure

Identifying the current total spend on services for the over 65s isn't straight forward, as NHS budgets are not always identified by age, but the table below provides a list of the those budgets that are most closely aligned with this programme and will be altered as investment is made in new community services that will lead to a reduction in hospital care expenditure.

Service Area	£'000s
NHS expenditure (2012/13)	
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
Subtotal	**51,519**
LBB expenditure (2012/13)	
Residential home placements	11,400
Nursing home placements	8,600
Extra care housing	4,400
Domically care packages	8,700
Carelink	700
Day Care	2,600
Reablement	1,300
Subtotal	**37,700**

Table 1- Current spend on services for people over 65 that are most closely aligned to the programme. Is not indicative of all costs associated with the over 65s

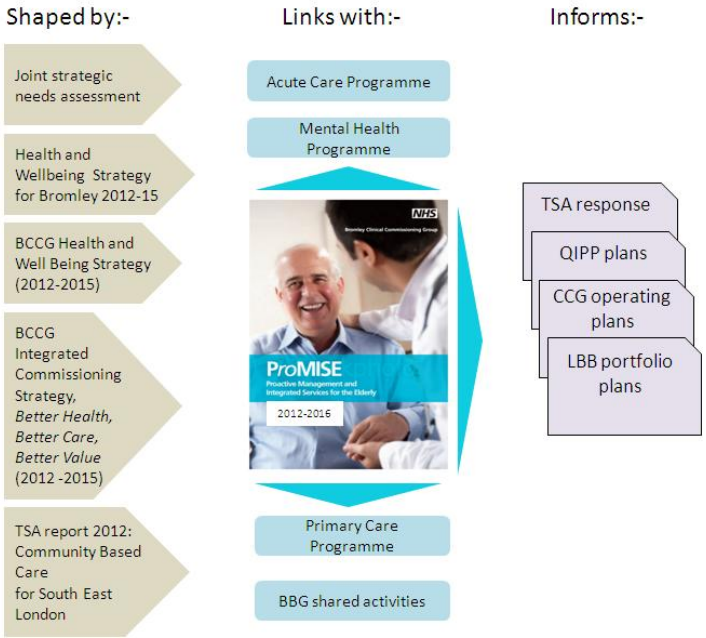
1.1.3 Strategic Fit

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 2013/2014 has further mandated the importance of demonstrating and evidencing health outcomes, many of which relate to both the elderly and long-term conditions.

This programme will ensure that the requirements of the Safeguarding Vulnerable Groups Act 2006 and the lessons from the recently published public enquiry into the Mid Staffordshire NHS Foundation Trust are incorporated into the commissioning of services for older people.

The P*ro*MISE initiative, which also seeks to improve services for people with long term conditions, is one of six major programmes of work being developed and delivered collaboratively to achieve the goals and strategic objectives set out in both the Health and Well Being Strategy (2012-2015) and the Integrated Commissioning Strategy, Better Health, Better Care, Better Value (2012 -2015). It should also be noted that many of the projects that fall within this programme will contribute to both the CCG Delivery Plan 2013-14, the CCG Strategic Plan 2013-16 and the annual Quality, Innovation, Productivity and Prevention (QIPP) submissions to the NHS National Commissioning Board.

Last year's 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, has also influenced the content and focus of P*ro*MISE. Appendix 1 of the TSA report: Community based Care for South East London highlights many of the characteristics of an effective community based health service that is required to enable the hospital sector to operate more efficiently. Crucially, it is essential that this Programme delivers the necessary changes to reduce hospital admissions and shorten their stay by caring for them safely in the community. Diagram 1 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.



1.2 Current provision of service

Current provision for the over 65s is provided through a typical range of community and hospital services, local pharmacies and social services, with primary care as the central interlinking service. Over the years are a number of multidisciplinary/agency teams have been established to streamline the assessment of need and deliver more integrated packages of care. These services are:

- A single point of contact for social care in Bromley known as social services direct (BSSD)
- A single point of entry (SPE) for health needs assessment
- Reablement team providing short-term domiciliary interventions
- A rapid response service to assess and administer treatment in people's homes
- Multi-disciplinary long-term conditions team
- A post-acute care enablement (PACE) service and intermediate care beds (Orpington Hospital and Elmwood nursing home) that are focused primarily (but not exclusively) on rehabilitating people after a stay in hospital
- Assisted living service at Crown Meadow Court
- Community assessment and rehabilitation teams (CARTS)
- A specialist community rehabilitation Neurology (SCREHN) service, concentrating on treating people who have suffered a stroke or head injury
- A small number of community matrons helping to coordinate the care of the frail and elderly

Discussions between GPs, BCCG and LBB have identified a number of opportunities to further improve care and ensure that today's limited funding can be used more efficiently. Table 2 below summarises some of issues that need to be addressed by this programme:

Issue	Current position	Future position
Public engagement in health issues	Limited public involvement in planning of service improvements	People should be routinely involved in not just service planning, but as partners in the management of their own health and well being.
Hospital admissions	Greater number of older people admitted to hospital as urgent cases than is necessary.	Improved range and integration of community services (see below) that are better able to care for people at home. Improved opportunity for people in the last year of life to die in their own home/place of choice
Diabetes O/P attendances, and surgical interventions	Secondary specialist based care with insufficient support in primary care	Enable more people with type II diabetes to be managed by primary care, reducing out-patient visits and hypoglycaemia events in A &E.
Self-Care	Limited opportunity for self-care	Development of support initiatives such as the Expert Patient Programme

		and Tele-health/ Tele-care
Team working	No clearly defined community teams	Defined teams of GPs, community health professionals and care workers looking after around 35,000 residents
Community services	A good range of reactive services such as Rapid Response, PACE, SCREHN, CARTS. Possible opportunity to streamline these services.	Services that anticipate people's needs and plan care in advance. Better coordination between professionals. Better access to diagnostic services to prevent unnecessary admissions

Table 2 Opportunities to improve primary and community care services

1.3 How P*ro*MISE has evolved

In 2012 commissioners developed a three year Integrated Commissioning Plan outlining the priority areas for shaping and delivering healthcare to Bromley residents. Improving services for older people was established as one of six strategic programmes.

During the past year, the early focus was on the development of case management using a risk stratification tool, which is described below. More recently a number of the ideas for suitable projects have been developed into full business cases (e.g. the proposal to establish a comprehensive service to prevent falls and fractures), whilst other ideas are still under development. The governance arrangements are now up and running and a small management team has been assigned to the programme.

2.0 The programme details

2.1 The vision for future services

We have a clear vision for the future of health and wellbeing for the elderly residents of Bromley. We believe that both the NHS and Social Services should provide "better" care for residents in the community, closer to home, improving quality of life and avoiding unnecessary hospital visits or admissions. However, it is vital that these changes are systematic, clinically sound, financially viable and self-sustaining.

Community services will be radically reorganised around local populations and their General Practices, leading to improved 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 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 also make it easier to engage more effectively with voluntary groups and also help foster a federated approach to primary care, whereby the specialist skills of clinicians could be made available not only to their own registered patients, but shared for the benefit of the wider 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 and

inconvenient care. 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. See diagram 1 below.

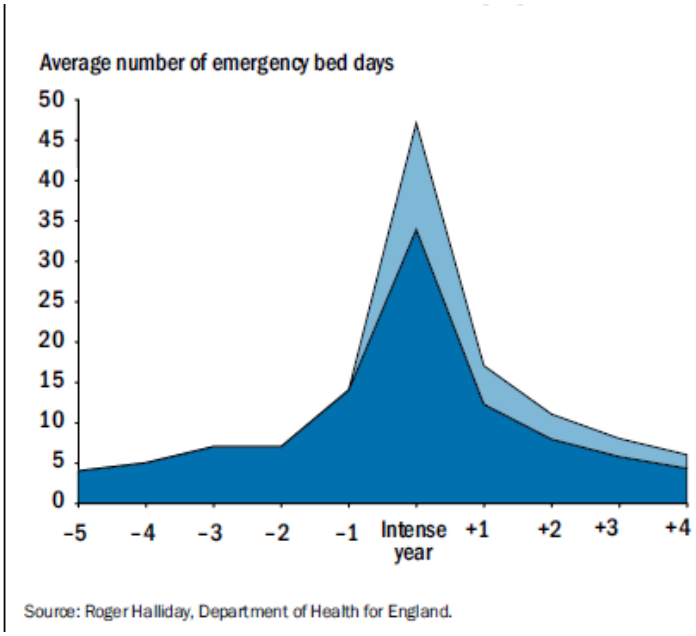


Diagram 1

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 Telehealth initiatives, expert patient programmes, support for more timely diagnosis in nursing and residential homes and enhanced end of life services. The unscheduled care programme is also exploring options to develop additional intermediate care services, which together with this and the other BCCG programmes will enable more people to be cared for safely in the community.

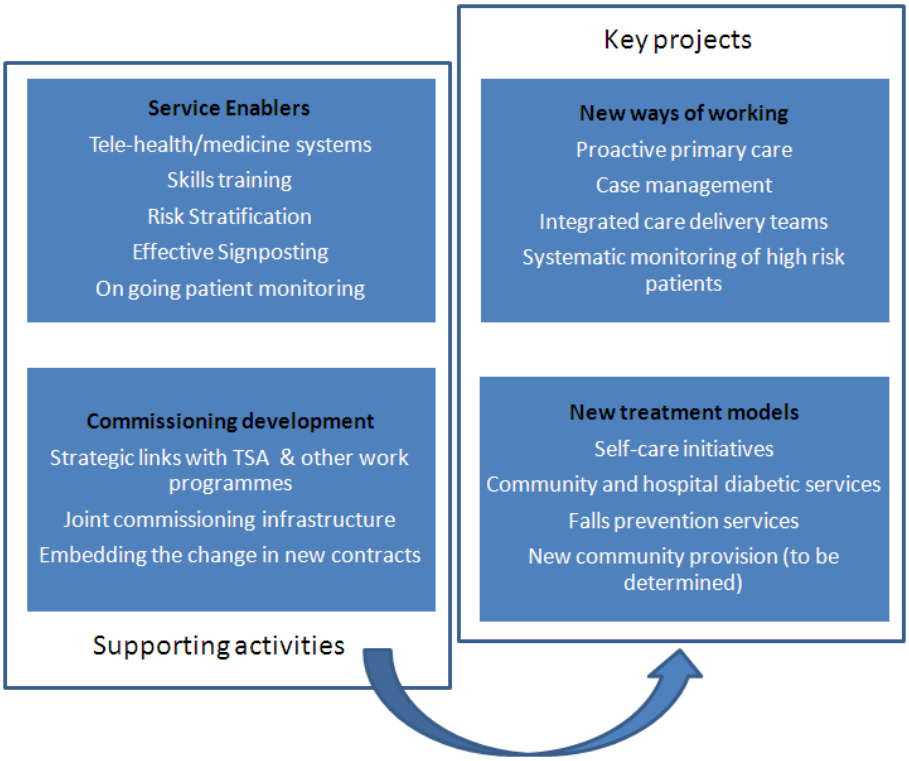
Crucial to the success of this programme is the recognition that these improvements need to be implemented across that whole of Bromley. Piecemeal service development and ad-hoc changes to team working will not deliver the scale of service change that is required. The purpose of this programme is to transform 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.

3.0 The programme content

3.1 Project Mapping

In earlier versions of this programme's documentation, the key projects and activities associated with ProMISE had been grouped together under four headings. These headings and their associated work lists have now been updated following further conversations with stakeholders (see below)

and now show the relationship between the key projects and the support activities necessary for success.



3.2 The Key Projects

This section provides a brief summary of each project, their anticipated measures of success and how they contribute to the BCCG strategic priorities (Appendix 1), the NHS National Outcomes Framework and their alignment to nationally recognised high impact innovations.

The TSA "Community Based Care" report also details a number of aspirations for community services. Those that are particularly relevant to this programme are:

- Having access to support to manage their own health and the confidence to make their own decisions
- Proactively identify and support more patients before a crisis and develop a care plan
- Have a named care coordinator
- Know that their GP is working within a multi-disciplinary group of health professionals
- Access to relevant & complete information in the right formats to inform personal choice and decisions

With respect to the overall programme, several high level outcome measures are being developed. (These are detailed in Appendix 2)

3.2.1 Case Management

Case management involves using a computer based tool to identify those people who are at risk of needing very high levels of service in the immediate future and agreeing with the individual (and their carer where appropriate), a personalised care plan that aims to reduce the chance of needing unplanned care or becoming more dependent on other services.

Outcomes	**Independence & Health**								Estimated at 1,011 fewer hospital admissions			
	Full year commissioning budget saving								****£1.754M**** see comment below			
	Service Satisfaction								To be benchmarked by BHC in April/May 2013			
Alignment to Objectives	**Alignment to CCG Strategic Objectives**								1, 4,5, 12, 16 & 18			
	Alignment to National/ Local Outcomes Indicators 2013/14 framework								2.2, 2.3, 2.6, 4.6 & 4.9			
	Alignment to High Impact innovations								Support for carers with people with dementia			
Project Timetable	**FY 2013 - 2014**				**FY 2014 - 2015**				**FY 2015 - 2016**			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	I	**I**	**I**	**I**	**I**	**I**	**I**	**R**				

3.2.2 Integrated Care

Establishes clearly defined teams of professionals within specified localities to improve communication and learning between the various professional disciplines. This will lead to more streamlined, better co-ordinated services.

Outcomes	**Independence & Health**								Estimated at 1,011 fewer hospital admissions			
	Full year commissioning budget saving								****£1.754M**** see comment below			
	Service Satisfaction								To be benchmarked by BHC in April/May 2013			
Alignment to Objectives	**Alignment to CCG Strategic Objectives**								1, 5, 12, 15, 16, 17, 18 & 20			
	Alignment to National/ Local Outcomes Indicators 2013/14 framework								2.2, 2.3, 2.6, 3.6, 4.6 & 4.9			
	Alignment to High Impact innovations								Support for carers with people with dementia			
Project Timetable	**FY 2013 - 2014**				**FY 2014 - 2015**				**FY 2015 - 2016**			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	D	**I**	**I**	**I**	**I**	**R**	**I**					

3.2.3 New intermediate care step-up services

This project is currently being developed by the unscheduled care programme team. Evidence from those health systems that have significantly reduced their hospital admissions, will typically have in place a range of community based services that enable more people to be cared for safely at home. *The impact of these services appears strongest when they are implemented alongside proactive case management and integrated care.*

Outcomes	**Independence & Health**								Estimated at 1,011 fewer hospital admissions			
	Full year commissioning budget saving								****£1.754M**** see comment below			
	Service Satisfaction								To be benchmarked by BHC in April/May 2013			
Alignment to Objectives	**Alignment to CCG Strategic Objectives**								1, 5, 12, 15, 16, 17, 18 & 20			
	Alignment to National/ Local Outcomes Indicators 2013/14 framework								2.2, 2.3, 2.6, 3.6, 4.6 & 4.9			
	Alignment to High Impact innovations								Support for carers with people with dementia			
Project Timetable	**FY 2013 - 2014**				**FY 2014 - 2015**				**FY 2015 - 2016**			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	D	**P**	**I**	**I**	**I**	**R**	**I**					

**** It should be noted that the three projects of Case Management, Integrated Care and New Community Services have a **combined** potential saving £1.7m. It is not possible to separate the financial impact of each project individually from the available evidence****

3.2.4 Falls and Fracture Prevention

The aim of this service is to identify those people at risk of sustaining a fracture or falling and developing with the individual a plan of preventative measures (both clinical and non-clinical)

Outcomes	**Independence & Health**								Estimated at 144 fewer admissions (urgent surgical) and fracture clinic attendances			
	Full year commissioning budget saving								Estimated at £247K			
	Service Satisfaction								To be benchmarked by BHC in April/May 2013			
Alignment to Objectives	**Alignment to CCG Strategic Objectives**								1, 10, 12, 13, 15, 16, 17, 18 & 20			
	Alignment to National/ Local Outcomes Indicators 2013/14 framework								3.5 & 4.9			
	Alignment to High Impact innovations											
Project Timetable	**FY 2013 - 2014**				**FY 2014 - 2015**				**FY 2015 - 2016**			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	D	**P**	**I**	**I**	**R**	**I**						

3.2.5 Community and Hospital Diabetic Services

This project aims to implement a new model of care based upon the evidence of good practice from Portsmouth and Derby. There will be a clearer distinction between what is delivered in the acute, community and primary care settings. The skills of GPs and other primary care staff will be enhanced and together with a community based specialist service, will lead to a reduction in both planned and unscheduled hospital attendances. **This project will be delivered by the planned care programme.**

Outcomes	**Independence & Health**	Hospital activity reduction: 8 primary coded and 296 secondary coded admissions via A & E. 6,519 Out-patient visits(note that a good proportion of the O/P visits will now take place in the community)										
	Full year commissioning budget saving	Estimated at £855k										
	Service Satisfaction	To be benchmarked by BHC in April/May 2013										
Alignment to Objectives	**Alignment to CCG Strategic Objectives**	1, 2, 12, 13, 15, 17, 18 &20										
	Alignment to National/ Local Outcomes Indicators 2013/14 framework	2.2, 2.3, 4.9										
	Alignment to High Impact innovations	N/A										
Project Timetable	**FY 2013 - 2014**				**FY 2014 - 2015**				**FY 2015 - 2016**			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	P	**I**	**I**	**I**		**R**	**I**					

3.2.6 End of Life Care

To reshape the services provided by St Christopher's hospice to ensure greater consistency of end of life care pathways, enabling more people to die at home if they wish. Central to this project will be the establishment of a 24 hour, 7 days per week care coordination centre.

Outcomes	**Independence & Health**	Estimated at 48 fewer hospital admissions										
	Full year commissioning budget saving	Estimated at £72k										
	Service Satisfaction	Fewer deaths in hospital? (55.9% of residents currently die in hospital) To be benchmarked by BHC in April/May 2013										
Alignment to Objectives	**Alignment to CCG Strategic Objectives**	1, 12, 15, 17, 18, 19 & 20										
	Alignment to National/ Local Outcomes Indicators 2013/14 framework	4.6 & 4.9										
	Alignment to High Impact innovations											
Project Timetable	**FY 2013 - 2014**				**FY 2014 - 2015**				**FY 2015 - 2016**			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	S	**D**	**P**	**I**		**R**	**I**					

3.2.7 Self-Care & Monitoring Initiatives

This project is currently exploring the benefits of Telehealth/Telecare and expert patient programmes. Business cases are currently been developed for a text-based Telehealth system and other self-care initiatives.

Outcomes	**Independence & Health**								Fewer visits to the GP/Hospital Initial pilot to be learning scheme			
	Full year commissioning budget saving											
	Service Satisfaction								To be benchmarked by BHC in April/May 2013			
Alignment to Objectives	**Alignment to CCG Strategic Objectives**								2, 3, 4, 8, 12, 15, 17, 18 & 20			
	Alignment to National/ Local Outcomes Indicators 2013/14 framework								2.2, 2.3 & 4.9			
	Alignment to High Impact innovations								3 Million Lives & Digital First			
Project Timetable	**FY 2013 - 2014**				**FY 2014 - 2015**				**FY 2015 - 2016**			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	S	**D**	**P**	**I**								

3.2.8 Urinary tract infections and associated conditions

This project is being developed in conjunction with the London Borough of Bromley, Bromley Healthcare and Carers Bromley to improve the early detection of urinary tract infections (UTI's), a common cause of hospital admissions in Bromley's elderly population. These UTI's can be distressing for residents and their carers and can be treated when detected early. It is recognised that UTIs can be a marker for other underlying problems, but by addressing the care pathway for UTIs, it is hoped to prevent these admissions too.

Outcomes	**Independence & Health**								99 fewer admissions			
	Full year commissioning budget saving								£243k			
	Service Satisfaction								To be benchmarked by BHC in April/May 2013			
Alignment to Objectives	**Alignment to CCG Strategic Objectives**								1, 10, 16, 18, 20			
	Alignment to National/ Local Outcomes Indicators 2013/14 framework								2.1, 2.2, 2.4, 4.6, 4.9			
	Alignment to High Impact innovations								N/A			
Project Timetable	**FY 2013 - 2014**				**FY 2014 - 2015**				**FY 2015 - 2016**			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	P	**I**			**R**	**I**		**R**				

3.2.9 Local Community Co-Ordination

The purpose of a Local Community Coordinator is to actively form partnerships with individuals, families and local communities to promote self-sufficiency and local solutions to problems. It also forms strong partnerships with formal services and professionals. In response to the complexities of the system, the benefits of investing in this innovative service are currently being explored.

<table>
<tr><td rowspan="3">Outcomes</td><td colspan="8">Independence & Health</td><td colspan="4">Benchmarking to be developed as part of the pilot</td></tr>
<tr><td colspan="8">Full year commissioning budget saving</td><td colspan="4">Initial pilot to be learning scheme</td></tr>
<tr><td colspan="8">Service Satisfaction</td><td colspan="4">Benchmarking to be developed as part of the pilot</td></tr>
<tr><td rowspan="3">Alignment to Objectives</td><td colspan="8">Alignment to CCG Strategic Objectives</td><td colspan="4">8, 16, 17 & 18</td></tr>
<tr><td colspan="8">Alignment to National/ Local Outcomes Indicators 2013/14 framework</td><td colspan="4">2.1</td></tr>
<tr><td colspan="8">Alignment to High Impact innovations</td><td colspan="4">N/A</td></tr>
<tr><td rowspan="3">Project Timetable</td><td colspan="4">FY 2013 - 2014</td><td colspan="4">FY 2014 - 2015</td><td colspan="4">FY 2015 - 2016</td></tr>
<tr><td>Q1</td><td>Q2</td><td>Q3</td><td>Q4</td><td>Q1</td><td>Q2</td><td>Q3</td><td>Q4</td><td>Q1</td><td>Q2</td><td>Q3</td><td>Q4</td></tr>
<tr><td>S</td><td>D</td><td>I</td><td>I</td><td></td><td>R</td><td>I</td><td></td><td></td><td></td><td></td><td></td></tr>
</table>

3.3 Supporting activities

The following tables now summarise the likely content of each of the support activities that underpin the key projects. Once the scope of these activities is better defined, they will be developed into additional projects and managed alongside those listed in section 3.

<table>
<tr><td colspan="2">Information systems</td></tr>
<tr><td colspan="2"><u>Patient Information:</u> Central to the success of this programme will be the ability to provide information to local people enabling them to care for themselves if they are well enough and to professionals, allowing them to seamlessly deliver personalised care.
<u>Clinical Information:</u> The contract for United Health's risk stratification tool ends in the near future and a decision will need to be made as to whether to terminate or extend the contract, or substitute the tool for another.
The programme will explore what other systems are needed to deliver personalised practice care and enable more people to look after themselves more effectively.</td></tr>
<tr><td rowspan="3">Outcomes</td><td>Cost effective purchase of a suitable risk stratification tool for the medium term</td></tr>
<tr><td>Implementation of a suitable information system that will enable each locality to establish proactive and integrated care. An integrated patient assessment and monitoring system is an essential aspect of integrated care</td></tr>
<tr><td>A decision on information systems (not necessarily involving IT) that enable more people to better manage their own health at home.</td></tr>
<tr><td>Project status</td><td>Desk top research on potentially useful information systems to begin in January 2013</td></tr>
</table>

Primary care development	
Delivering proactive integrated care for older people is likely to require all professionals working in the community to change their daily routines. BCCG has established a primary care development programme to help practices prepare for the healthcare challenges that lie ahead. In order to facilitate the changes, pump priming incentives monies may be used to accelerate the uptake of new working practices	
Outcomes	Effective and systematic case management embedded within primary care. All practices utilising their Patient Liaison Office role.
	Completion of the training and development programme aligned with new service requirements. E.g. Diabetes Management
Project status	The requirements of the ProMISE programme have been incorporated into the CCG Primary Care Programme

Commissioning development	
The main purpose of this work stream is to develop, alongside the key projects, new contract currencies and performance arrangements to that will help embed new practices and assist with the evaluation of the new services and working arrangements. Bromley CCG and LBB have already established two joint commissioning roles and a third post is currently being recruited to for older people's services. In the light of the Francis Report into services provided by Mid Staffordshire Trust, one of the key tasks of this new function will be ensure there is transparency of service performance and user feedback that the multi-agency locality teams can share and acted upon.	
Outcomes	New joint performance management arrangements
	New contracts that supports integrated care
	New contracts for new service pathways
Project status	Recruitment underway for joint commissioner of older peoples services

Training and development for new professionals	
If successful, this programme will change many of the roles and responsibilities in the community. Consideration will therefore need to be given to future training, placement and education curriculum for new professionals. The programme must ensure it develops linkages with the Local Education and Training Board (LETB)	
Outcomes	Agreement with LETB on future training, placements and education curriculum for professional training
Project status	LETBs to be informed of progress during 2013, in advance of the new service models that will become more established during 2014/15

Communications	
Effective communications will be crucial to the success of this project	
Outcomes	The development of a P*ro*MISE communication strategy for the CCG, BHC and LCBB by Aril 2013. The development and implementation of a patient engagement strategy
Project status	Development of the communications strategy currently in draft form.

4.0 Financial summary for the programme

A summary statement is shown below in table 3 (over page). It should be noted that this table shows the revenue savings that will be generated against the cost of the overall programme budget. With the exception of the falls and fracture prevention project that has now been developed into a full business case, the costs and projected savings for the other projects are preliminary at this stage. All projects that require funding will be submitted to the CCG in accordance with Standing Financial Instructions.

The financial projections indicate that in year three, the programme will deliver just under £3.2 million pounds worth of recurring savings, which has been counted against the QIPP target. These savings will repay the cost of the programme investment in year 4. This schedule assumes that in year three, the recurring project investments begin to be transferred to the community service commissioning budgets.

The end column in the table above shows the impact on commissioning budgets in year three. Approximately £5.3 million pounds of savings will be made from acute hospital budgets, following £2.1m worth of investment in the community. This “invest to save” ratio of 0.39 is in line with the predicted of 0.40 ratio detailed in the TSA report.

	2013 -14 ProMISE £0's	2014-15 ProMISE £0's	2015-16 ProMISE £0's	All years ProMISE £0's	CCG Budgets £0's	Full Year CCG £0's
Case Managment/Integrated & Intemediate care						
Recurring project investments	£545,800	£1,149,600	£566,500	£2,261,900	£583,100	£1,149,600
Projected Recurring Savings Gross	-£180,000	-£1,449,000	-£1,210,000	-£2,839,000	-£1,694,000	-£2,904,000
Projected Recurring Savings Net	£365,800	-£299,400	-£643,500	-£577,100	-£1,110,900	-£1,754,400
Falls Project						
Recurring project investments	£192,671	£301,273	£75,318	£569,262	£225,955	£301,273
Projected Recurring Savings	-£102,799	-£521,717	-£137,060	-£761,576	-£411,181	-£548,241
Projected Recurring Savings Net	£89,873	-£220,444	-£61,742	-£192,313	-£185,226	-£246,968
Diabetes						
Recurring project investments	£143,566	£359,235	£387,828	£890,629	£129,276	£517,104
Projected Recurring Savings	-£102,929	-£823,435	-£686,196	-£1,612,561	-£686,196	-£1,372,392
Projected Recurring Savings Net	£40,637	-£464,200	-£298,368	-£721,932	-£556,920	-£855,288
End of Life						
Recurring project investments	£58,000	£120,000	£60,000	£238,000	£60,000	£120,000
Projected Recurring Savings	-£43,000	-£192,000	-£96,000	-£331,000	-£96,000	-£192,000
Projected Recurring Savings Net	£15,000	-£72,000	-£36,000	-£93,000	-£36,000	-£72,000
Teleheath/medicine						
Recurring project investments	£10,500	£42,000	£42,000	£94,500	£0	£42,000
Projected Recurring Savings	£0	-£38,500	-£42,000	-£80,500	£0	-£42,000
Projected Recurring Savings Net	£10,500	£3,500	£0	£14,000	£0	£0
UTI						
Recurring project investments	£6,588	£3,624	£3,624	£13,836	£0	£3,624
Projected Recurring Savings	-£106,665	-£242,880	-£242,880	-£592,425	£0	-£242,880
Projected Recurring Savings Net	-£100,077	-£239,256	-£239,256	-£578,589	£0	-£239,256
TOTALS						
Recurring project investments	**£957,125**	**£1,975,732**	**£1,135,270**	**£4,068,127**	**£998,331**	**£2,133,601**
Projected Recurring Savings	**-£535,393**	**-£3,267,532**	**-£2,414,136**	**-£6,217,061**	**-£2,887,377**	**-£5,301,513**
Projected Recurring Savings Net	**£421,732**	**-£1,291,800**	**-£1,278,866**	**-£2,148,934**	**-£1,889,046**	**-£3,167,912**
Non Recurrent Project Investments						
Case Managment/ Integrated Care & New Services	£1,870,506	£246,500	£0	£2,117,006	£0	£0
Falls Project	£56,000	£42,000	£0	£98,000	£0	£0
Diabetes	£172,434	£89,572	£12,292	£274,298	£0	£0
End of Life	£35,000	£14,000	£0	£49,000	£0	£0
Teleheath/medicine	£134,000	£278,000	£0	£412,000	£0	£0
Fixed Costs (Overheads) - All Projects	£282,600	£102,600	£102,600	£487,800	£0	£0
Total Non Recurrent Investements	**£2,550,540**	**£772,672**	**£114,892**	**£3,438,104**	**£0**	**£0**
Total Investment	**£3,507,665**	**£2,748,404**	**£1,250,162**	**£7,506,231**		

Table 3. P*ro*MISE three year financial summary

5.0 Programme Governance

5.1 Managing the programme management

5.1.2 Business case requirements

Projects in the programme will be developed by a nominated project manager and full business cases will be submitted to the CCG Programme Board, the Strategic Planning Group and the Governing Body in accordance with standing financial instructions.

Each project should demonstrate:

- The proposed service redesign reflects the needs and views of local users and carers
- The system is adopting existing innovation and best practice
- The project offers value for money for the taxpayer
- There is the necessary scale, pace and ambition to make the required impact
- Existing resources should be maximised before additional funding is requested
- How commissioning is to be developed along-side the project to embed the changes, using new contract measures and incentives etc.

5.1.4 Strong clinical and professional leadership

In addition to the BCCG senior team, the nominated clinical leads for this programme are Dr Ruchira Paranjape and Dr Mandy Selby. The programme also has access to a Clinical Advisory Group to test that the proposals are safe, make good clinical sense and are deliverable.

5.2 Project management structures

Governance & Decision Making Arrangements:

Programme Board- is chaired by Dr Paranjape (Principle Clinical lead) and has representatives from Bromley CCG, London Borough of Bromley, Bromley Healthcare and GP Clinical Leads. The Board will endorse business cases for onward discussion at the Strategy and Planning Group.

Membership:

Chair	Dr Ruchira Paranjape
Clinical Lead	GP Lead- Dr Mandy Selby
Programme Lead	Paul White
CCG	Kate Dawes, Programme Manager
	Meredith Collins, Director of Healthcare System Reform
	Mark Cheung, Chief Financial Officer,
	Sonia Colwill, Director of Quality, Governance and Patient Safety
LBB	Lorna Blackwood, Assistant Director for Social Services

Programme Implementation Group- is chaired by the Programme Lead and is responsible for performance managing the programme delivery. This implementation group is directly responsible to the Programme Delivery Group that monitors all the BCCG programmes.

Membership:

Chair	Paul White
Programme Manager	Kate Dawes
Clinical Leads	Dr Mandy Selby and Dr Ruchira Paranjape, Darzi Fellow
CCG	Helen Evans, Lead Community Matron, Ellen Baldry, Programme Administrator, Sarah Osborne, Head of Planning and Performance, Lucy Cole, Head of Financial Planning and Strategy
BHC	Andrew Hardman, Joint Clinical Director BHC.
LBB	Tricia Wennell, Head of Assessment and Care Richard Hills, Strategy Manager, Commissioning

The diagram below illustrates the programme structure, for which all terms of references can be found in Appendix 3.

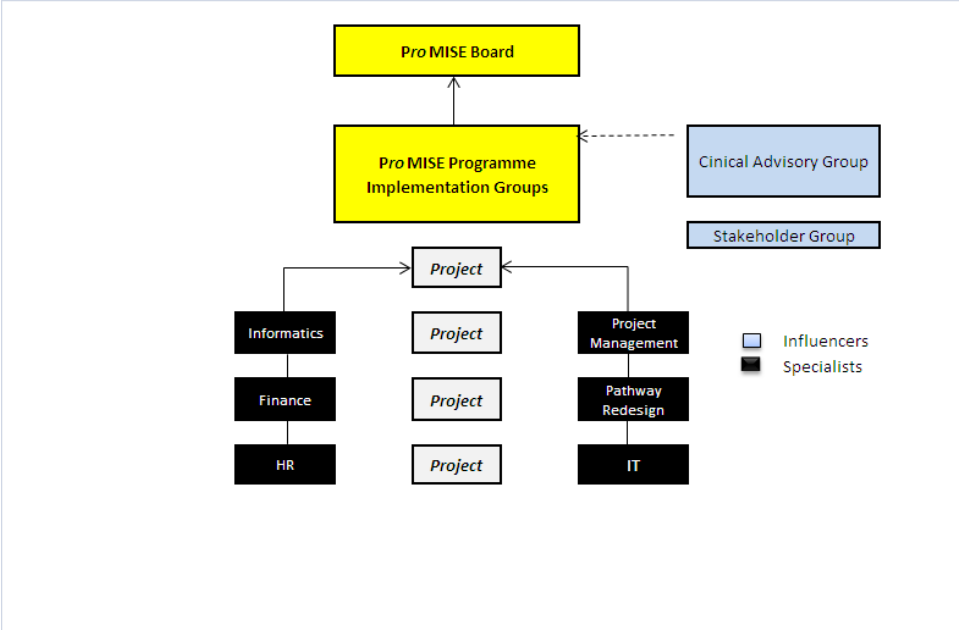
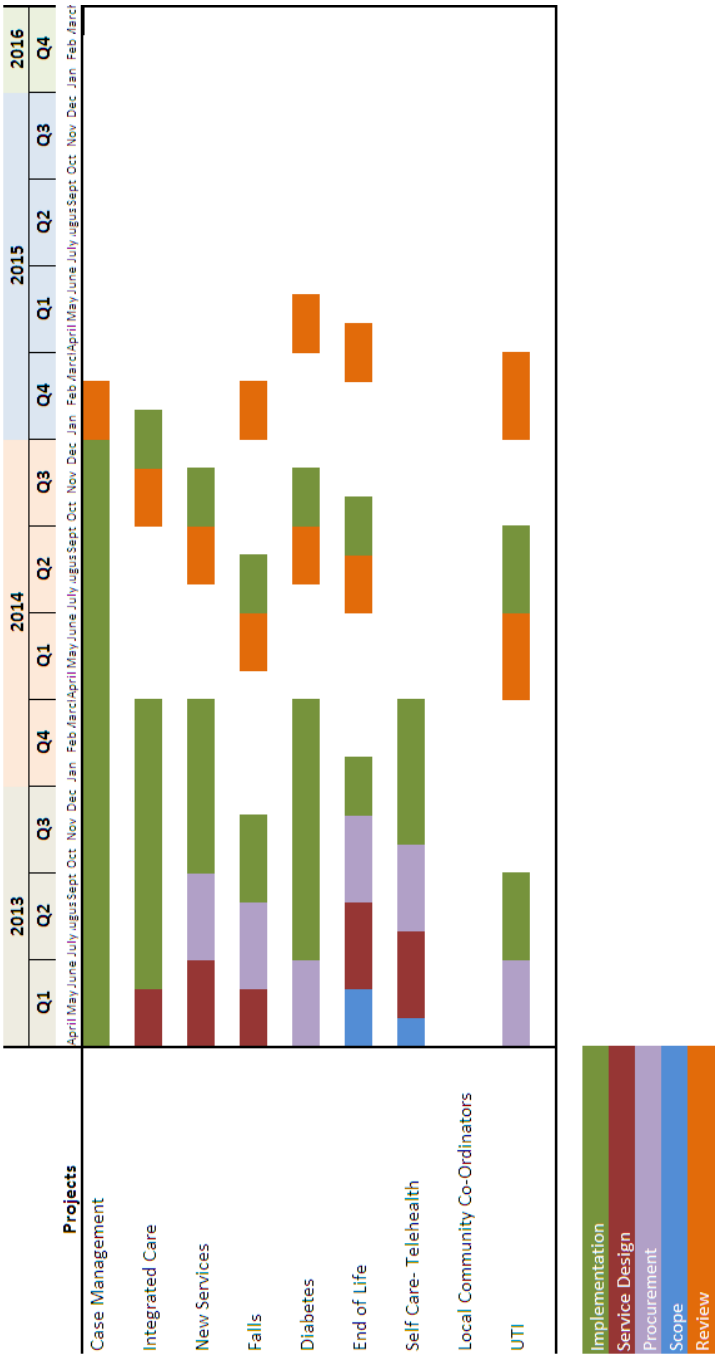


Diagram 2 Programme governance arrangements

6.0 Timetable

The table below shows the provisional scheduling of the key projects from April 2013. The Projects have been broken down into five phases. Scope, Design, procure, Implementation and review.



7.0 Risk assessment

The need to change the day to day working routines of many community based professionals is central to this programme. Table 4 highlights a number of the risks associated with the delivery of this programme and the actions proposed to mitigate these risks.

Risk	Impact	Probability	Mitigation	Owner	New risk assessment
TSA pace of change outstripping developments to increase the capacity of the community services	High	Medium	Accelerate and focus the P*ro*MISE programme on those projects that are expected to have maximum impact. Strengthen the involvement of BHC and agree on how best to scale the development of integrated services	Programme Lead	Medium
Weak initial evidence for the Risk Stratification Pilot	Medium	High	Need to build consensus across primary care using examples for other CCGs	Programme Lead	Medium
Availability of outcomes data to demonstrate the effectiveness of integrated care	Medium	High	Develop proxy measures including utilisation of resources	Programme Lead	Low
Poor engagement from Primary care	High	Medium	Develop an effective communication strategy and ensure that P*ro*MISE informs and dovetails with the primary care development programme to align incentive schemes etc.	Programme Lead	Low
The NHS dominates the programme with short-term initiatives at the expense of important longer-term well being initiatives	Medium	Medium	Ensure that the Local Community Co-ordinators project is adequately funded and given priority alongside more immediate admission avoidance schemes	Programme Lead	Low
Local Borough of Bromley disengage from programme due to high unfunded shift of costs from NHS to Social care budgets	Medium	Medium	Build in cost shifting monitoring arrangements from the outset, giving early warning of unexpected service costs. Consider developing shared risk and benefits contracts.	Programme Lead	Low
Savings fail to materialise because external service models used as evidence do not “localise” effectively	High	Medium	Make prudent savings assessment, and update the models as new evidence emerges. Visit other CCGs to better understand how to established effective integrated services	Programme Lead	Low
Contract savings do not materialise because thresholds for admission fall	High	Medium	Ensure that bed reductions are delivered as part of the TSA recommendations	Programme Lead	Low
Insufficient communications support	High	Medium	Consider funding additional capacity from the programme funds	Programme manager	Low

Table 4 P*ro*MISE risk assessment

8.0 Recommendations and decisions

The Health and Well Being Board is asked to:-

- Note the scope of the ProMISE programme.
- Note that funds held under Section 256 will be used to pump prime many of the projects

Appendix 1

As taken from Bromley CCG *"Better Health, Better Care, Better Value"*

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. Emergency re-admissions
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	Develop Clinical protocols to increase the proportion of A&E patients accessing the UCC (PRUH)	Better Care Better Value	Proportion of patients seen in UCC (PRUH)
7	Improve safety of maternity services	Better Care	Dashboard of maternity and perinatal indicators.
8	Reduce health inequalities across the	Better Care	Differential best to

	Bromley borough by working in partnership with LBB and others, including patients and service users by prompting self-care/ management of their condition.	Better Health	worst wards. Patients in self-care schemes.
9	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.
10	Develop pathways to facilitate the achievement of A&E 4 hour wait targets	Better Care Better Value	4 hour wait (95%) at Princess Royal University Hospital.
11	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%)
12	Achieve financial balance through judicious budgetary control and an innovative approach to commissioning	Better Value	Achievement of planned surplus
13	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.
14	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.
15	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.
16	Promote joint working with London Borough of Bromley to maximise potential from joint resources.	Better Care Better Value	Value of schemes managed with an integrated approach.
17	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
18	Develop the Care Closer to Home agenda to maximise productivity in care pathways.	Better Care Better Value	Number and value of schemes providing services in non-acute setting.
19	End of Life Care	Better Care Better Value	% of deaths that occur at preferred place of choice (recorded in Advanced Care Plans)

20	Quality of Services	Better Care	Dashboard of quality indicators to be developed.

Appendix 2

		Measure	Quantify	Where?
Improved outcomes- health and wellbeing and independence	Health Outcome Independence Reduction in referrals through LBB for social care need	Risk stratification score and personalised care plan (CBC) Barthel - no. of steps able to walk - Interactions with social groups - Ability to manage own drugs Fewer GP Contacts Reduction in calls Reduction in calls referred to the assessment team at Social Services	10% few A&E visits for diabetic hypo To reduce to below the national average (baseline 2012) patients requiring foot and toe amputations	UHE tool Barthel assessment for pre and post EMIS Web LBB system LBB call dashboard
Cost effectiveness	Reduction in acute spending Reduction in social care spending for 65+	Reduction in non-elective admissions for the over 65s Reduction in GP visits No increase in spend for residential care No increase in nursing home placements No increase in the average weekly unit cost of domiciliary budgets	1,462 fewer urgent medical admissions 144 fewer falls admissions To be benchmarked 391 per yr. Ave weekly spend. £560.00 244 per year Ave weekly spend £680	Readmission rates SUS data SUS data SUS data EMIS Web LBB system

Resident satisfaction with the services	Quality Dignity Friendly/Courteous More equipped to cope with condition	Picker or equivalent Baseline compared with post intervention score	Baseline line of resident satisfaction is currently being undertaken by Bromley Healthcare	Patient Questionnaires & Patient assessment forms Barthel