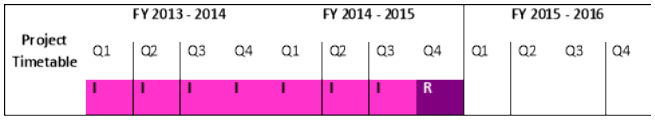
Programme Overview

	Care plan	Frequency of review	Access to rapid response?	Active case management ?	Pro-active screening?	Project areas
Highest Risk	Yes- likely that this will be a range of End of Life Coordination Services or Community Matrons	As required	Yes	Yes	Falls, dementia, medicines management, EoL screening at each appointment/ assessment	End of Life Coordination, Care Planning, Virtual Ward, Integrated Teams, Improved Discharge
High Risk	Yes- this will include coordination from the integrated care teams, initially assessed by the ProMISE CMs	Monthly- Six weekly	Yes	Yes	Falls, dementia, medicines management, EoL screening at each appointment/ assessment	Case Management : ProMISE, Care Planning, Integrated Team, Improved Discharge, Falls and Fracture, Flo
Medium Risk	Yes- likely to be managed by primary and community care	Quarterly	Yes- unlikely to need	No	Falls, dementia, medicines management at each appointment/ assessment	Self Care, Care Planning, Integrated Teams, Falls & Fracture, Flo
Low Risk	Low risk patients will be encouraged to undertake self care led care planning and some may benefit from a care plan	Annually	Yes- unlikely to need	No	Falls, dementia, medicines management at each appointment	Expert Patient, Self Care, Care Planning, Falls and Fracture Prevention

Case Management Update



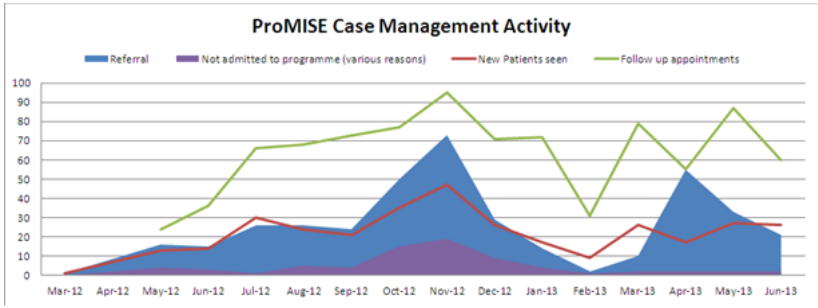
I- Implementation, R- Review

Confidence Matrix		
Rating Type	**RAG**	**Comments**
Quality of Planning		On track
Likelihood of delivery		Phasing and savings may slip due to low referral rates
Budget status		Minimal spend to date, other than PMO costs
Capability status		Capacity issues may impact

Phases	GP Surgeries
Phase 1	Ballater Surgery, Chislehurst, Knoll Medical Practice, Links- Mottingham, Links- Downham, Southborough Lane, Stock Hill, Whitehouse Surgery
Phase 2	Green Street Green, Dysart, Derry Downs, Bank House, Cornerways, Bromley Common, Southview Lodge
Phase 3, Tranche 1	Woodlands, London Lane, Cator, Elm House, Wickham Park
Phase 3, Tranche 2	Poverest, St Mary's Cray, Trinity, Chelsfield, Sundridge, Pickhurst

Key Milestones Achieved

- Phase 1, 2 and 3 Tranche 1 risk stratification patients ran and seen.
- 21: 46 of GP Practices within ProMISE
- Total of 395 patients seen (equivalent to 1227 contacts)
- Balanced scorecard developed and ratified
- Care Plan reconfigured and updated on to EMIS system for operational ease
- Memorandum of understanding, including data sharing agreed
- Phasing of handover to BHC of Phase 1 & 2 patients agreed with BHC
- Invested in Community Matron capacity within ProMISE and BHC
- DES agreed and implemented for incentivisation of Care Planning and risk profiling with emphasis on a multi -disciplinary approach
- 39:49 Practices have opted in to the Direct Enhanced System- equivalent to 295,206 of the total Bromley population. 3396 residents will be directly affected (1:1000 per month per surgery- not just >65yrs)



Risks

	Title	Description	Owner	RAG	Mitigation Actions Taken in Period
1	Stakeholder buy-in	GPs will need to recognise that they will be key to case management of patients & support & encourage their role within this.	KD		Comms and Engagement Plan to ensure steps for successful engagement. Presenting at Cluster meetings, information via news weaver and relationship management
2	Ownership of the case management aspect of the programme	Discord and disagreement relating to who case manages patients	PW		Ongoing discussion with various provider stakeholders to flesh out the operations of this.
3	Technologies and Information Systems	Each agency has a different information system, which do not communicate with one another	KD		New technologies will be required to ensure that systems are aligned/ communicate. Data sharing contracts will be mandated BHC to use EMIS Web
4	Information	BCCG unable to access patient level data for risk strat updates	SO		Meeting with NHSL for a work around regarding the contracts. Interim solution- GPs are to use their own clinical knowledge, supported by other info, e.g. housebound register, falls registers etc

Outlook for next period

- Pseudonymised data being monitored but issue relating to United Health and data sharing.
- Recruit GP/IT Lead
- Review of original assumptions of activity, e.g. condition type, complexity
- Full engagement and comms plans to be developed in partnership with Comms colleagues at LBB
- Commencement of assessments of Phase 3, tranche 2 patients by ProMISE Matrons
- Commencement of assessment of newly identified patients in Phases 1 & "
- Sending out MoU to all Ph1 & 2 practices, for further access to systems and agree new process

Integrated Care

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					

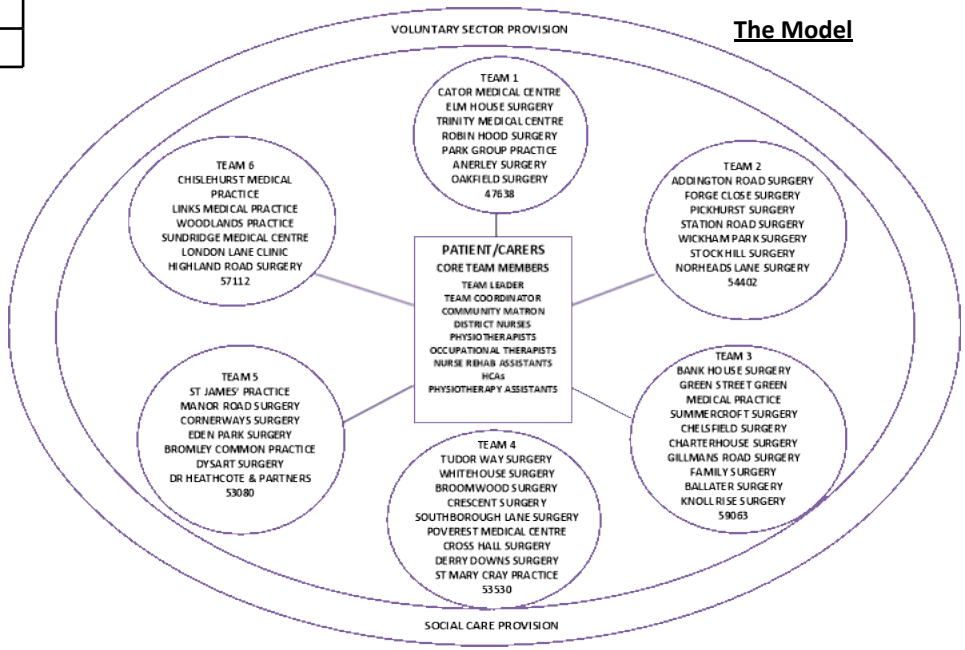
D- Design, I- Implementation, R- Review

Confidence Matrix		
Rating Type	**RAG**	**Comments**
Quality of Planning		On track
Likelihood of delivery		Steady progress being made. Internally the BHC team is aiming for roll out in November 2013
Budget status		The restructure of the current BHC resources is being carried out within existing budgets
Capability status		

Key Milestones Achieved

- Development and design of the model
- GP and stakeholder engagement for wider resource inclusion- LBB, Oxleas, Voluntary Sector
- Roll out of Pilot- included 4 practices from March 2013- July 2013
- Inclusion of LBB Social Worker as part of the pilot team
- Pilot Project Evaluation produced
- Community Health Team structures and GP groupings ratified
- Development of full implementation plan
- Staff consultations commenced for remodelling BHC workforce

The Model



Risks

	Title	Description	Owner	RAG	Mitigation Actions Taken in Period
1	GP Engagement	Good positive buy in for the project from pilot GPs. Work still needs to be achieved around comms and attending appropriate meetings	AH		Integrated team have increased presence in the surgery, attending MDT practice meetings GP Cluster meeting attended
2	EMIS Web	Information sharing agreements to be agreed	RS		Ongoing dialogue with BCCG Developing dialogue with GPs and LMC Community Matrons being given access to EMIS Web EMI(S Steering Group commenced
3	Staff Consultation	Staff engagement and consultation key and needs to be carefully managed	RS		Staff engagement meeting scheduled and feedback has been positive
4	Suitability of estates	The current estates may not be fit for purpose to support integrated community team working	RS		Review of estates requirements and resource is underway.

Outlook for next period

- Further GP engagement
- Plans to include the rest of the Practices in Team One ahead of the November 2013 roll out
- Staff engagement to continue
- Staff consultation to commence early August 2013
- Evidence based and data analysis framework to be developed- shared data analyst now in post
- Outcomes Frameowrk development – to be reviewed by CAG
- Oxleas to propose a parallel integrated model for their CPNs to that of BHC
- Falls Prevention to go live
- Awaiting proposal from Bromley Links regarding the improved coordination of voluntary services to support a more integrated approach for individual patients.