London Borough of Bromley

PART ONE - PUBLIC

HEALTH AND WELLBEING BOARD

Date:	**Thursday 28 November 2013**
Report Title:	**ProMISE (Proactive Management of Integrated Services for the Elderly) Programme Three year expenditure plan**
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1. SUMMARY

1.1 In 2012, Bromley Clinical Commissioning Group developed its first three-year Integrated Commissioning Plan, outlining the priority areas for shaping and delivering healthcare to the people of Bromley. Long-term conditions and care for older people was identified as one of six strategic programmes that constituted the plan; focusing on systemic change of care delivery, service integration and a proactive and holistic approach to the care of patients. This programme was branded as ProMISE.

1.2 Radical cultural, operational and service change is required to achieve our ambition and central to the ProMISE programme is a determination to systematically change the way in which health and social care is delivered.

1.3 The primary aim of ProMISE is to shift the requirement of unplanned care delivered in an acute (secondary care) setting, after reacting to an unpredicted health crisis, to a more proactive approach.

1.4 The overarching principles behind the work rest upon our ability to prevent this group of complex and often older patients from worsening ill health and to maintain and promote independent high standards of living. Risk stratification is now capable of identifying those patients at higher risk of their chronic and complex health issues escalating to a point of needing secondary care intervention. This in turn enables us to offer individualised case management in a community setting with a range of additional support services aimed at maintaining and improving their current health.

1.5 Since April, the programme has progressed markedly. We are beginning to see tangible benefits of the many component enabling projects. We are building a system that anticipates, identifies and responds to individual needs and can help keep local people out of hospital and residential/nursing homes where appropriate. There is growing evidence that a significant reduction to emergency bed days and/or early admission to residential or nursing homes is achievable with the use of case-finding and proactive intervention for patients before their “intensive year” of need.

1.6 There is an expectation, moreover, that earlier intervention and the active promotion and support for self-management will reduce the overall burden on health and social care services in the medium to longer term.

2. REASON FOR REPORT GOING TO HEALTH & WELLBEING BOARD

2.1 The challenge of providing health and social care for an ageing and growing population, within limited resources is well-documented 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.

2.2 Latest demographic figures quote the Bromley registered population of 312,3541. 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.

2.3 With residents living longer, greater pressure is being put on the system. As demonstrated in the Joint Strategic Needs Assessment (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 with multi-agencies, which are likely to be more costly on already restrained budgets

2.4 Key disease challenges for the area relate to 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 is a precursor to heart disease or stroke.
- Respiratory conditions are prevalent in the area also and represent almost 13% of total deaths in Bromley, including influenza and chronic obstructive pulmonary disease.
- Dementia is becoming increasingly more prevalent with an increase in the over 65s population and further emphasis is required to identify and treat the condition.

2.5 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.

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

2.7 Due to the complexity and extent of co-morbidities of elderly patients, this cohort prove to be both high activity users, regularly accessing GP practices, hospitals, clinics, social services, community care and pharmacies.

2.8 The ProMISE programme aims to address many of the challenges and the identified priorities within the Health & Wellbeing Strategy: Diabetes, Hypertension, Anxiety & Depression, Dementia and Supporting Carers.

[1] Taken from Registered patient data from 1/1/2012 provided by Bromley CCG Informatics Team

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

3.1 The programme budget for ProMISE stands at £7.5 million and is held under a Section 256 agreement with the London Borough of Bromley.

3.2 The purpose of this report is to:

- provide an update, in accordance with the terms of the Section 256 agreement - updating the three-year investment programme and reporting on progress with its constituent projects;
- seek Health & Wellbeing Board support for the release of funds specific to programme related activities in 2013/14 - subject to ratification by the Executive of the Local Authority
- seek Health & Wellbeing Board support for the planned expenditure in 2014/15 and 2015/16, recognising that whilst there may be subsequent revisions to the breakdown of the investments these will not result in a material change to the overall expenditure plan - subject to ratification by the Executive of the Local Authority; and
- note that the Health & Wellbeing Board will continue to receive regular progress reports.

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4. COMMENTARY

The following summarises progress being made against each of the defined projects within the programme and the measurable impact of the investments being made, where available:

- Case Management – twenty-one GP practices have been risk stratifying and referring suitable patients via the Bromley Healthcare Single Point of Entry (SPE) to dedicated community matrons within the ProMISE team. The matrons undertake bespoke home-based complex case assessments; coordinating any health and social care and voluntary sector input, both for the patient and any unpaid carer. They follow patients up after several weeks to sign off a care plan, which includes a self-care component. Analysis (still being validated) of 418 patients supported in this way suggests that this is having a significant impact on their demand for secondary care services:

Year on year financial comparison for ProMISE patient cohort (418 patients)

	Apr 2012 to July 2012		Apr 2013 to July 2013		Variation	
	Activity	**Spend**	**Activity**	**Spend**	**Activity**	**Spend**
A&E	282	£42,523	178	£26,230	-104	-£16,292
Inpatient Emergency	214	£590,624	91	£228,326	-123	-£362,298
Outpatient First	216	£51,006	116	£22,169	-100	-£28,837
Outpatient follow-up	369	£42,838	269	£33,185	-100	-£9,653
Total	**1081**	**£726,991**	**654**	**£309,910**	**-427**	**-£417,081**

This four month activity comparison relates to 18 GP practices covering 52% of the Bromley registered population

This information is still being validated but if accurate, as we believe, and extrapolated to Bromley-wide the full year effect in terms of avoided secondary care activity and spend could be:

	Activity	Spend	Activity	Spend	Activity	Spend
A&E	1627	£245,323	1027	£151,329	-600	-£93,994
Inpatient Emergency	1235	£3,407,446	525	£1,317,265	-710	-£2,090,181
Outpatient First	1246	£294,266	669	£127,898	-577	-£166,369
Outpatient follow-up	2129	£247,142	1552	£191,450	-577	-£55,692
Total	6237	£4,194,177	3773	£1,787,941	**-2463**	**-£2,406,235**

Analysis of the outcomes, suggests that patients identified through case management will typically require low level social care advice and support if any, with many of the patients identified as requiring such support often already know to the social care team. Of the 418 patients seen, for example, only fifteen required any form of social care intervention, with all the patients already known to social care and typically receiving low level support, such as drop-off to day-care facilities. Only three of the patients required reassessment following the input of the community matron and continued to receive low level support, thereafter.

- Integrated Care – Bromley Healthcare is responding to our commissioning strategy and reconfiguring its services to work in six co-located locality teams with effect from 2 December. Each team will work closely with a local group of GP practices covering registered populations of approximately 50,000 residents. Dedicated and additional community matrons will be undertaking home-based complex case assessments and care planning and multi-disciplinary teams will work closely with GP practices, named mental health and social care staff and newly commissioned enhanced end of life care services to manage effectively patients with complex needs and/or long-term conditions.

  In one of the six localities, an integrated care team pilot already underway will shortly be introducing a dedicated community psychiatric nurse to work full-time with Bromley Healthcare; working with the community matrons and multi-disciplinary teams and bringing a primary mental health presence to the locality. We are working with local authority colleagues with a view to bringing a similarly dedicated and ideally co-located social care manager/assistant to the team. The expectation being that this will enable closer, better coordinated and therefore more effective working for the benefit of Bromley residents. We will also take the opportunity of this extended pilot to very carefully monitor the impact of this proactive and integrated way of working on primary, community, mental health and social care services.

  Analysis to date suggests that there is unmet need for therapies among the patients referred for case management and it is likely that further investment in occupational therapists and physiotherapists will be required to support the more proactive management of patients in the community and their own homes, whilst there may need to be further but non-recurrent investment in district nurses as we effect the transformation from a community caseload largely derived from reactive provision to one largely derived from proactive care.

  Following changes to rules relating to the sharing of patient identifiable data at local level, the risk stratification tool that had been supporting case management is no longer viable. GP practices have been relying instead on clinical judgement to identify patients suitable for assessment and care planning but this has reduced throughput. The ProMISE team is now working with EMIS to develop and implement a new predictive risk tool that relies solely upon GP practice data, thereby overcoming the restrictive changes to information sharing. Investment in training and development and user licences over the next three years will need to be made to achieve this.

Significantly, Bromley Healthcare are adopting EMIS as their patient record system, whilst 43 of 46 GP practices in Bromley also use the system. This offers the further opportunity of developing EMIS as the basis for an integrated shared care record. The significance of this is not to be underestimated. It could place Bromley at the forefront, by realising an information system that supports truly integrated working; greatly enhancing our ability to offer holistic and coordinated care to patients with complex needs and/or long-term conditions.

- Falls and Fracture prevention – Bromley Healthcare will be accepting referrals from GP practices into their newly commissioned service from 25 November and from other healthcare professionals from January. The ProMISE programme has also incentivised GP practices to set up falls registers, identifying patients with a history of falls or perceived higher risk of falling, i.e. due to other health conditions perceived frailty, social isolation and polypharmacy issues. New falls clinics based in multiple community settings staffed by a Falls Coordinator, nurse, consultant, physiotherapist and occupational therapist will be seeing up 30 patients a week. Whilst a new Fracture Liaison Nurse, working with a counterpart being recruited by King's Healthcare NHS Foundation Trust, will be seeking patients in A&E and fracture clinics with fragility fractures (which are indicative of osteoporosis) for DEXA scanning and osteoporosis treatment, as well as seeking non-fracture fallers for referral to the community falls clinics. Finally, this greatly enhanced package will be complemented by weekly exercise and balance classes at multiple community locations across Bromley. This service should prevent falls and fractures arising from falls, as well aiding the recovery from falls.

- Diabetes – the ProMISE programme is supporting the development of the primary care workforce, through a comprehensive training programme now underway, and the redesign of diabetes pathways incorporating the provision of an advanced primary care service. The aim is to ensure that every person with diabetes in Bromley receives personalised care from trained primary care healthcare professionals with faster access to specialist care, advice and support as and when required.

  The investment will:
  - help ensure that NICE guidance outcomes are met by all GP practices (currently 50% compliance); that the Diabetes UK 15 care essentials are met through basic level training for GP practices (currently variable);
  - mean that specialist resources are accessed more appropriately and effectively (currently inappropriate use of specialist services for routine care);
  - support fast access to specialist advice (neither timely nor coordinated currently);
  - support the accredited training of GPs and nurses to provide insulin management (currently little or no education and training otherwise available with variable standards)
  - help create a single, dedicated specialist team (consultant and diabetes nurse) working across secondary and community care is in place (currently limited availability and capacity and poor coordination across the two sectors)

  The benefits for patients will be:
  - local access to a full range of services;
  - personalised care plans in primary care, shared with secondary care;
  - responsive services with improved access to specialist care when required
  - improved clinical outcomes through a proactive and responsive truly integrated and trained workforce to consistent standards of care.

  Secondary benefits:
  - overall reduction in diabetes related morbidity and mortality and associated complications such complex neuropathy and renal failure

This development recently received recognition by way of an innovation reward for 'pushing the boundaries of diabetes care in primary care' from the South London Membership Council

- End of Life Care – the St Christopher's Group will be commencing a newly commissioned enhanced end of life care service from the start of December. They will be providing a new 24 hour coordinated care centre for patients and carers – case-finding coordinating and directing care for a further 800 patients per annum; ensuring that the patients are on the Continuing My Care register; ensuring that care plans are in place with the appropriate partners; attending relevant multi-disciplinary team and GP practice meetings; working closely with discharge co-ordination teams at the Princess Royal University Hospital; and coordinating the attendance of end of life care personnel at GP practice Gold Standard Framework or hospital multi-disciplinary team meetings. The aim is for admissions in the final year of life and deaths in hospital to be avoided by supporting patients to enable them to remain and die at home, should they wish. ProMISE monies will be ring-fenced in 2013/14 to fund any additional community equipment costs arising and arrangements have been established with our colleagues in the local authority to both enable access and monitor demand.

- Self-care and monitoring – FLO is a low cost and very simple healthcare system provided via the patient's own mobile phone or landline. It is primarily an automated SMS (text) messaging based system that clinicians use to send reminders, health tips and advice to patients; and collect, monitor and track their health readings taken by the patient using self-monitoring equipment e.g. Blood pressure machines. Patients can text back their readings to FLO. Text messages to FLO for patients are free even if the patient has no credit.

  More than 30 GP practices have enrolled and patients are being signed up to the self-monitoring scheme. The priority condition chosen for monitoring is hypertension; a recognised priority health need in Bromley. Other protocols covering asthma, COPD and smoking cessation are also being adopted this year.

  The evidence, resulting from evaluations of FLO around the country, shows clear health benefits for the patients and productivity benefits for clinicians. We have developed pre- and post- FLO patient questionnaires to measure whether patients feels better equipped and more confident to self-manage and are less reliant on primary care consultations than before. We have also developed a GP practice questionnaire to gauge their confidence and satisfaction with the system. Finally, subject to the limitations upon access to patient identifiable information, we are attempting to set up monitoring of actual primary care consultations, A&E attendances and admissions for individual patients pre- and post-FLO; to measure the impact of close and frequent monitoring and timely responses to changes in patients' vital signs.

  Following a recent options appraisal, plans for investment in self-care are being further developed in three distinct areas:
  - information and advice;
  - self-management; and
  - training of healthcare professionals in motivational coaching

  Self-care is anticipated to be a commissioning priority going forward as it is felt to have the potential to impact greatly upon future demand for health and social care. Any further investment will need to be targeted in those areas that have the potential to achieve the greatest impact and any case for investment will be underpinned by demonstrable local need, supporting evidence of success and value for money.

- Patient Liaison Officer (PLO)scheme – the ProMISE programme is now supporting this highly innovative primary care workforce development initiative that has attracted national recognition. A second series of workshops in early 2014, will result in almost 100 GP practice receptionist and administrators having developed a new set of skills. The role envisaged is not dissimilar to that of a hospital Patient Advice & Liaison Service (PALS) but the PLO aims to support vulnerable patients and carers in anticipation of their needs rather than respond to a problem; the aims being to prevent problems, avoidable admissions and poor communication. The PLO will support proactive integrated care and more effective communication and coordination between patients (and carers) and integrated care teams, whilst reducing the administrative burden of care on GPs which in turn affords them more time to focus on meeting the needs of their most complex and elderly patients.

  The ProMISE programme is supporting two GP practice initiatives to enable PLOs to apply the skills learned and to begin to deliver their anticipated role - trained PLOs are creating falls registers and carer registers in their practices. The PLOs are identifying patients who have a history of or are at perceived risk of falling, linking to the new Falls service described above. They are also identifying and considering carers as vital members of an integrated care team; as important stakeholders in the design and delivery of services; and as patients with their own health and support needs.

- Urinary Tract Infection (UTI) training – there are many admissions of people aged 65 and over with UTIs which can often be prevented if identified and treated earlier. We have set up free training sessions for non-clinical nursing and care home staff, domiciliary care workers, day centre staff, the reablement team and informal carers. Each session provides information about the causes of a urine infection, prevention, symptoms and common treatments. Carers also learn how to carry out a urine 'dipstick test', which can help exclude or confirm the presence of a urine infection and enable earlier treatment as appropriate.

  Community Matrons are now delivering the training at a range of venues across Bromley and after a slow start the numbers have now increased significantly, with considerable support from colleagues within the London Borough of Bromley to market the training. There have been almost 250 applications for training and already three UTIs have been identified in residential care homes, which if left untreated would most likely have led to hospital admission and, given the age of the patients (105.100 and 85) may have led to prolonged stays and further complications. We intend to continue to market and run free training sessions for the remainder of this year and throughout 2014/15.

5. FINANCIAL IMPLICATIONS

The funding for this programme is derived from health monies now held by the London Borough of Bromley having been transferred by way of a Section 256 agreement.

The spread sheet included with this report (Appendix A) summarises the £7.5 million programme expenditure plan for 2013 to 2016. A detailed breakdown of all expenditure on a month by month basis for each individual project is available should any member require it.

The spread sheet also encompasses the net savings assumptions associated with this programme. The savings are those anticipated from shifting the requirement of unplanned care delivered in an acute (secondary care) setting after reacting to an unpredicted health crisis, through the act of forecasting individual patient needs for care and support which can be delivered in the community (primary care) and the service user's own home.

There is increasing evidence of the benefits of proactively helping people to stay well and at home wherever possible for both the individuals and their families in terms of quality of life and outcomes and in terms of reducing emergency bed days. However, there may be concern that this

approach will create other cost pressures across the local health and social care economy. Any discernible evidence of the impact on social care and other services to date has been highlighted, in section 4 below,

The savings that this programme generate in conjunction with the Integration Transformation Fund should support further investment in out of hospital services, where appropriate and evidenced, as part of the ongoing strategy to transform the way that health and social care services are delivered.

The savings that the different projects under this programme generate can be reinvested across Bromley's health and social care system in support of the prevention agenda and to reduce our reliance on high cost, long term bed-based care. Funding will continue to be realigned to develop and support out of hospital services, where appropriate and evidenced, as part of the ongoing strategy to transform the way that health and social care services are delivered.

This one-off programme spend on Promise puts Bromley in a strong position and compliments the upcoming work required locally by the CCG and London Borough of Bromley to deliver a two year local plan for the use of the Integrated Transformation Fund (ITF).

6. LEGAL IMPLICATIONS

Nothing to add further to section 5 above.

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

None identified.

8. COMMENT FROM THE DIRECTOR OF AUTHOR ORGANISATION

I have read and support this report, both in terms of its contents and recommendations.

Appendix A

NEW SERVICES	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	13-14 Gross QIPP £0's	14-15 Net QIPP £0's	15-16 Net QIPP £0's
Case Management & Integrated Care									
Project investments	£150,000	£1,137,000	£1,137,000	£2,424,000	£0	£1,137,000			
Projected Savings Gross	-£180,000	-£1,449,000	-£1,210,000	-£2,839,000	-£1,694,000	-£2,904,000			
Projected Savings Net	-£30,000	-£312,000	-£73,000	-£415,000	-£1,694,000	-£1,767,000	-£180,000	-£132,000	-£1,455,000
Falls Project									
Project investments	£100,424	£301,273	£75,318	£477,015	£225,955	£301,273			
Projected Savings	-£36,941	-£773,677	-£209,102	-£1,019,720	-£627,306	-£836,408			
Projected Savings Net	£63,483	-£472,404	-£133,784	-£542,705	-£401,351	-£535,135	-£36,941	-£435,463	-£62,731
Diabetes									
Project investments	£103,846	£395,258	£344,834	£843,938	-£193,595	£459,779			
Projected Savings	-£25,007	-£529,473	-£580,784	-£1,135,264	-£387,190	-£774,379			
Projected Savings Net	£78,839	-£134,215	-£235,950	-£291,326	-£580,784	-£314,600	-£25,007	-£109,208	-£682,519
End of Life									
Project investments	£103,542	£310,627	£155,314	£569,483	£155,316	£310,632			
Projected Savings	-£146,061	-£1,130,793	-£565,397	-£1,842,250	-£565,397	-£1,130,793			
Projected Savings Net	-£42,518	-£820,166	-£410,083	-£1,272,767	-£410,081	-£820,161	-£146,061	-£674,105	0
Teleheath/medicine									
Project investments	£28,000	£16,500	£16,500	£61,000	£0	£11,500			
Projected Savings	-£14,000	-£42,000	-£42,000	-£98,000	£0	-£42,000			
Projected Savings Net	£14,000	-£25,500	-£25,500	-£37,000	£0	-£30,500	-£14,000	£0	£0
Patient Liaison Officer									
Project investments	£0	£0	£0	£0	£0	£0			
Projected Savings	£0	£0	£0	£0	£0	£0			
Projected Savings Net	£0	£0	£0	£0	£0	£0	£0	£0	£0

UTI									
Project investments	£7,000	£4,013	£4,013	£15,026	£0	£4,013			
Projected Savings	-£77,906	-£306,516	-£306,516	-£690,938	£0	-£306,516			
Projected Savings Net	-£70,906	-£302,503	-£302,503	-£675,912	£0	-£302,503	-£77,906	-£224,597	£0
TOTALS									
Project investments	**£492,813**	**£2,164,671**	**£1,732,979**	**£4,390,463**	**£187,676**	**£2,224,197**			
Projected Savings	**-£479,915**	**-£4,231,459**	**-£2,913,799**	**-£7,625,173**	**-£3,273,892**	**-£5,994,096**			
Projected Savings Net	**£12,897**	**-£2,066,788**	**-£1,180,820**	**-£3,234,710**	**-£3,086,216**	**-£3,769,899**	**-£479,915**	**-£1,575,373**	**-£2,200,250**
INVEST TO SAVE & START UP COSTS							£475,389		
Case Management/Integrated Care (community matrons, integrated care pilot, community teams, risk software & training)	£613,600	£225,300	£400,000	£1,238,900	£0	£0			
Falls Project (includes GP register scheme)	£202,944	£31,200	£0	£234,144	£0	£0			
Diabetes (training of GP staff)	£119,202	£183,740	£55,290	£358,232	£0	£0			
End of Life (includes community equipment & rapid discharge service)	£211,960	£142,979	£0	£354,940	£0	£0			
Teleheath/medicine (includes licences, SMS messages and GP practice training)	£57,350	£0	£0	£57,350	£0	£0			
Patient Liaison Officer Scheme (GP practice staff training)	£29,225	£0	£0	£29,225	£0	£0			
UTI (consumables & carer training)	£31,200	£31,200	£0	£62,400	£0	£0			
Fixed Costs (Overheads) - All Projects	£342,873	£215,388	£215,388	£773,649	£0	£0			
Total Management & other Project Investments	**£1,608,354**	**£829,807**	**£670,678**	**£3,108,840**	**£0**	**£0**			
Total Investment	**£2,101,167**	**£2,994,478**	**£2,403,657**	**£7,499,302**					