**Report No.**
**CS14021**

# London Borough of Bromley

**PART ONE - PUBLIC**

| | |
|---|---|
| **Decision Maker:** | **Health Scrutiny PDS Committee** |
| **Date:** | **30th January 2013** |
| **Decision Type:** | Non-Urgent Non-Executive Non-Key |
| **Title:** | **ProMISE (Proactive Management & Integrated Services for the Elderly) programme** |
| **Contact Officer:** | Paul White, Associate Director of Development & ProMISE Programme Director<br>Bromley Clinical Commissioning Group<br>Tel: 01689 880567<br>E-mail: paul.white@bromleyccg.nhs.uk |
| **Chief Officer:** | Angela Bhan, Bromley Clinical Commissioning Group |
| **Ward:** | Borough-wide |

1. Reason for report

To inform the Committee of progress with Bromley Clinical Commissioning Group's ProMISE programme. The programme was presented to the November 2013 meeting of the Health & Wellbeing Board, who gave its support for the projects within the programme.

---

## 2. RECOMMENDATION(S)

The Members of the Committee are asked to note progress with the ProMISE Programme.

Corporate Policy

1. Policy Status: Not applicable
2. BBB Priority: The programme aims to address many of the challenges and the identified priorities described within the Health & Wellbeing Strategy: diabetes, hypertension, anxiety and depression, dementia and support for carers.

---

Financial

1. Cost of proposal: £7.5m over three years (non-recurrent)
2. Ongoing costs: N/A
3. Budget head/performance centre:
4. Total current budget for this head: £
5. Source of funding: NHS resources held under a Section 256 agreement

---

Staff

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

---

Legal

1. Legal Requirement: N/A

2. Call-in: N/A

---

Customer Impact

1. Estimated number of users/beneficiaries (current and projected): The programme is Bromley-wide with a primary focus on older people (there are approximately 60,000 people aged 65 and over living in Bromley) and people with complex health needs. In the longer term all Bromley residents have the potential to benefit from a programme aimed at delivering a more proactive, coordinated and integrated approach to the delivery of health and social care in Bromley.

---

Ward Councillor Views

1. Have Ward Councillors been asked for comments? No, reports on the ProMISE programme are given regularly to the Health & Wellbeing Board, however.
2. Summary of Ward Councillors comments:

## 3. COMMENTARY

3.1 Bromley Clinical Commissioning Group has identified long-term conditions and care for older people as one of its six strategic programmes. 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.

3.2 Central to ProMISE is a determination to systematically change the way in which health and social care is delivered; shifting the requirement of unplanned care delivered in an acute (secondary care) setting, after reacting to an unpredicted health crisis, to a more proactive, coordinated and integrated approach.

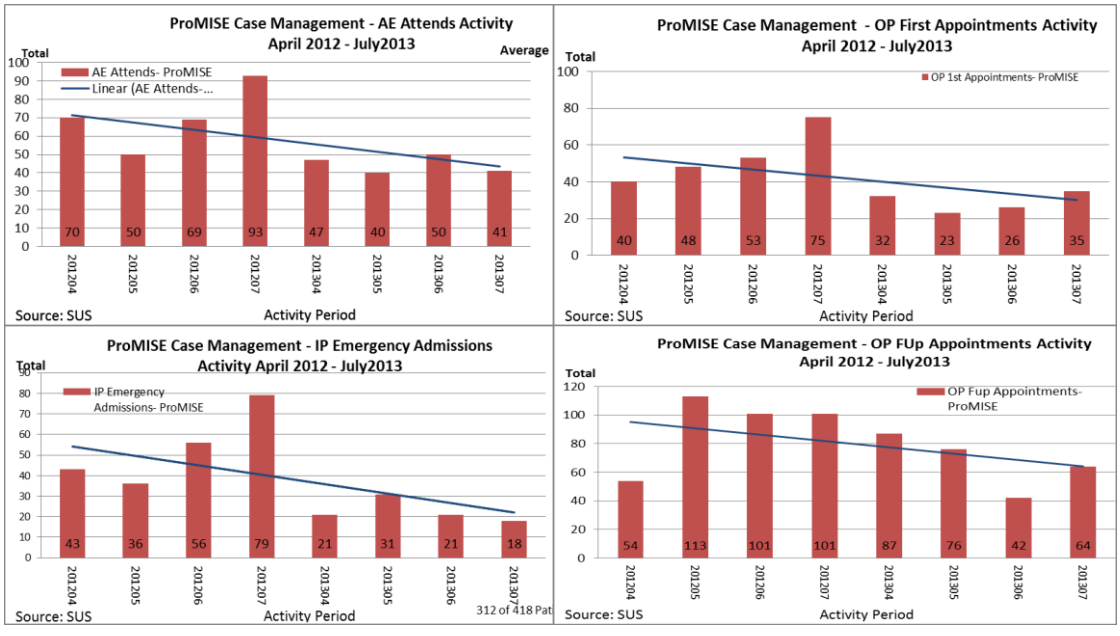
3.3 Success is dependent upon our ability to prevent complex and often older patients from worsening ill-health and to maintain and promote independent high standards of living. Risk stratification is now capable of identifying those patients at higher risk of their chronic and complex health issues escalating to a point of needing secondary care intervention. This in turn enables us to respond proactively, offering individualised case management in a community setting with a range of additional support services aimed at maintaining and improving their current health and quality of life and preventing the anticipated crisis.

3.4 We are now seeing tangible benefits of the many component enabling projects. We are building a system that anticipates, identifies and responds to individual needs and encourages and enables partnership working among health and social care professionals; to provide coordinated and person centred care that 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.

3.5 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.

3.6 The following summarises the individual projects that comprise the programme and where demonstrable the measurable impact that each is having:

- Case Management – twenty-one of forty-six 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 of 268 of the 418 patients supported in this way suggests this is having a significant impact on their demand for hospital services:



**Year on year financial comparison for ProMISE patient cohort (268 patients)**

| | |
|---|---|
| Total Spend 6 Months prior to ProMISE | £1,455,513 |
| Total Spend 6 Months post ProMISE | £747,813 |
| Avoided costs (6 month post ProMISE) | **-£707,700** |
| Avoided costs excluding elective admissions (6 month post ProMISE) | **-£546,804** |
| Avoided costs unscheduled care only (6 month post ProMISE) | **-£487,532** |

This activity comparison relates to 18 GP practices covering 52% of the Bromley registered population and is limited to 268 of the 418 patients supported on the basis of the availability of six months of post-ProMISE intervention hospital data.

If this impact were extrapolated to encompass all GP practices in Bromley, the full year effect in terms of avoided secondary care activity and spend could be:

If all practices were on the Programme with 1.3% (average of practices analysed above) of over 65s actively managed:

| | | |
|---|---|---|
| Total No. Patients | | **705** |
| | | |
| Potential cost avoided | All Activity | **-£1,861,673** |
| | Excluding Elective | **-£1,438,421** |
| | Unscheduled Care Only | **-£1,282,500** |

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 already known 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 has reconfigured its services to work in six co-located locality teams. 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 has introduced 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. Similarly, we are working with local authority colleagues to bring a similarly dedicated and 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. The plan is to have an interim solution in place by April 2014 and to commence roll-out of the new tool from July 2014.

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 is now accepting referrals from GP practices into their newly commissioned service and will shortly be accepting referrals from other health and social care professionals; approximately thirty GP referrals were made to the new service in December. 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 is now providing an enhanced end of life care service. They are 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 (there has already been a marked improvement that has seen Bromley move into the top five best performing CCGs across London); 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.

  Thirty-five GP practices have enrolled and patients are being signed up to the self-monitoring scheme (80 patients signed up as at the end of December). 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 261 applications for training with seventeen training sessions held. Nine UTIs have been identified to date, which if left untreated would most likely have led to hospital admission. The feedback from course attendees has been excellent and we intend to continue to market and run free training sessions for the remainder of this year and throughout 2014/15.

## 4. FINANCIAL IMPLICATIONS

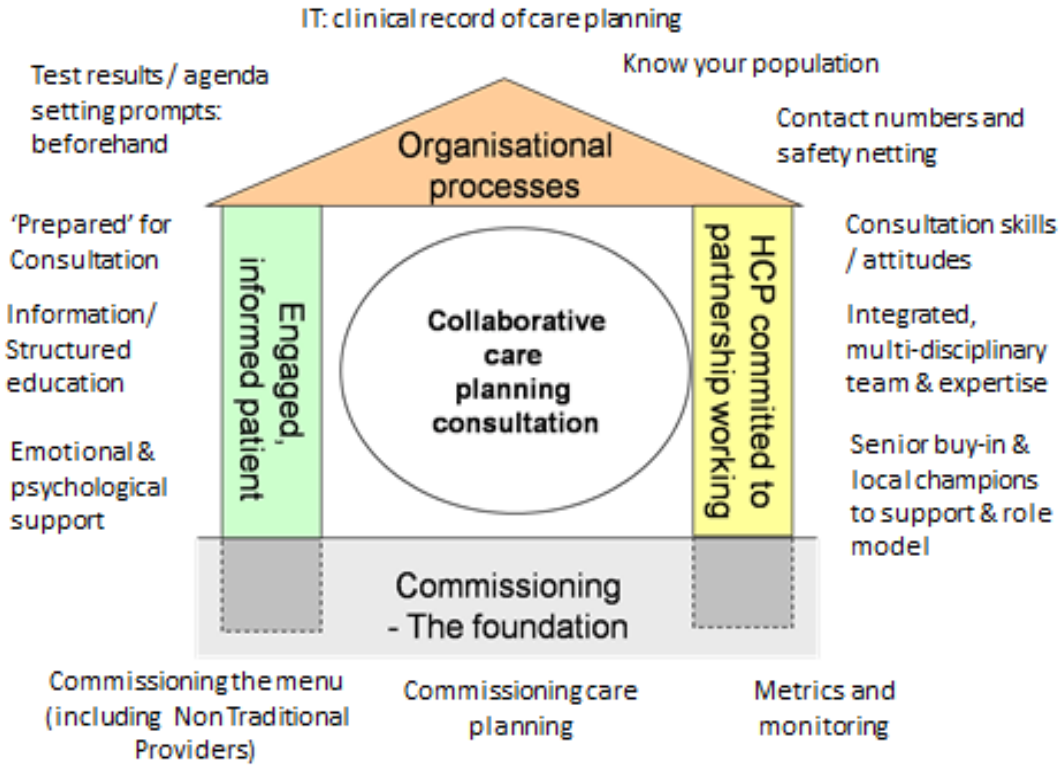
4.1 The funding for this programme is derived from health monies now held by the London Borough of Bromley, having been transferred by way of a Section 256 agreement. The Executive

approved the release of ProMISE funds for the activities for 2013-14 and approved planned expenditure for 2014/15 and 2015/16 at its meeting held on 15 January 2014.

## 5. POLICY IMPLICATIONS

5.1 With the advent of the Better Care Fund, colleagues across the Clinical Commissioning Group and London Borough of Bromley are now collaborating to use the Fund not purely as a vehicle for funding the back-fill of existing social care budgets, but as the focus for working jointly across health, social care and the third sector to reduce long-term dependency, promote independence and drive overall improvements in health and wellbeing; moving from a reactive, bed-based model of provision to a proactive community and home-based model with a strong emphasis on self-care for the individual and their "community" and with providers working collaboratively to deliver person centred and coordinated care in partnership with local people and their carers.

5.2 We have begun to describe this concept as the "House of Care"




5.3 In building our Bromley 'House of Care', non-recurrent additional investment will be made in skills, capacity, behavioural and cultural change, equipment and infrastructure across health and social care to secure person-centred, safe, needs driven, high quality and integrated alternatives to secondary and nursing home care services and enhanced rehabilitation / reablement services which will reduce hospital readmissions and admissions to residential and nursing home care.

5.4 We will also invest in empowering local people through effective care navigation and a menu of self-management options ranging from advice and information, education, support for carers, access to telehealth and health coaching to maximise their independence and wellbeing; and we will help identify and combat social isolation, as a major influence on overall health and wellbeing, with initiatives such as the award winning Bromley Leg Club and through closer and more effective collaborative working with communities through our partners across the third sector.

5.5 We are enhancing our already effective risk stratification and care planning tools in health to work effectively across social care also. We are aiming to develop a single care planning tool and interoperability between all systems that will provide both real time information and managerial analytics, starting by ensuring that GP and Social Care systems across Bromley are integrated around the NHS number.

5.6 In summary, the BCF will enable us to start to release health funding to establish accessible and integrated services that proactively work with current and future high risk individuals, irrespective of eligibility criteria.

5.7 This more coherent, joined up and proactive approach in both commissioning and provision will improve our efficiency and the management of demand within both the health and care systems and reduce the reliance upon high cost emergency care beds. In turn, this will enable us to work sustainably within our current and future organisational resources, in the face of an increasingly ageing population, whilst simultaneously expanding the range of services and improving the quality of outcomes for individuals. and reduce the reliance upon high cost emergency care beds. In turn, this will enable us to work sustainably within our current and future organisational resources, in the face of an increasingly ageing population, whilst simultaneously expanding the range of services and improving the quality of outcomes for individuals.

| **Non-Applicable Sections:** | **Legal and Personnel** |
|---|---|
| Background Documents: (Access via Contact Officer) | [Title of document and date] |