The Bromley Out of Hospital Transformation Programme

1. Strategy Summary

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2. Core narrative

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3. BROMLEY'S HEALTH AND CARE ECONOMY IS UNBALANCED AND REQUIRES REFORM

Largely for historical reasons Bromley is a challenged health and care economy which contains imbalances in the pattern of care provided. Amongst other challenges it faces;

- A low level of integration
- Patchy secondary and tertiary prevention
- Rising healthcare demand that is unaffordable, leading to a projected £72.3 million gap by 2020
- Being overwhelmed by short term performance issues, which deflects focus away from preventative and proactive models of care

BROMLEY NEEDS TO '**BREAK THE LOCK'** THAT HISTORICAL ISSUES HAVE HELD ON THE HEALTH AND CARE SYSTEM TO MEET THE FUTURE AFFORDABILITY AND DEMAND CHALLENGE

BREAKING THE LOCK REQUIRES A NEW MODEL OF CARE – THIS IS EASY TO SAY BUT HARD TO DELIVER

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4. THE LOCK ON TRANSFORMATION MUST BE BROKEN

A number of factors have combined to create a cycle of adverse pressure in the Bromley health and care system. These include;

DIABETES IS THE MOST PREVALENT CHRONIC DISEASE IN BROMLEY	•13,681 local residents are on the diabetes register (2012/13) •This represents 5.2% of the local population •Prevalence is rising, doubling from 1.7% in the decade to 2013
OTHER PREVALENT CHRONIC DISEASE WITHIN THE BROMLEY WARD PROFILE INCLUDE:	•Asthma (5.3% prevalence) •Hypertension (14% prevalence) •Coronary heart disease (3.1% prevalence)
IN PEOPLE AGED OVER 65, LIMITING LIFE-LONG ILLNESS IS PRESENT IN 23,612 LOCAL RESIDENTS	•This represents 42% of people aged over 65 •Overall, this accounts for 7.5% of the local population •An additional 10,704 of people aged >65 have mobility issues
THERE ARE 19,590 PEOPLE WITH A MODERATE OR SEVERE PHYSICAL DISABILITY	•This represents 6.2% of the local population •Of the local population, 1.4% have a severe physical disability •Of those with a moderate/severe physical disability, 9136 require personal care
THERE ARE 5,891 ADULTS IN THE BOROUGH WITH A LEARNING DISABILITY	•This represents 1.9% of the local population •Of these, 4727 are aged 18-64 and 1,164 are aged >65 •Of these adults, 21% have a moderate/severe learning disability

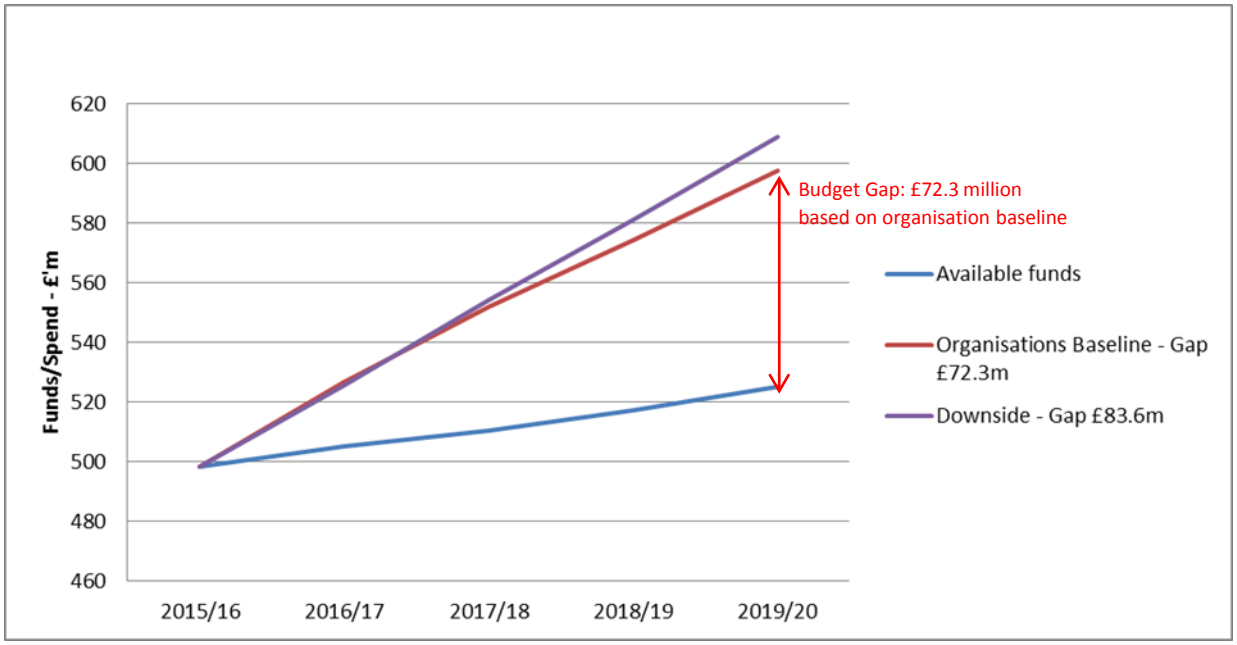
- Long term conditions are increasing, against a backdrop of a growing older population, which is creating increasing demand for the local health and social care economy.
- There is growing gap between demand and affordability which requires transformative action to resolve.
- Integrated delivery of health and social care can address this gap, but currently providers in Bromley are not designed, staffed or incentivised to deliver this appropriately.
- As a result, levels of out-of-hospital integration are very low, with relatively little multi-disciplinary team working. The situation is further exacerbated by performance challenges at an acute care level, which leads to increased pressures and demand in the system as a whole.
- Taken together these factors create a cycle of urgency and fire-fighting in which the health and social care system is less able to invest in transformation for the medium term.

Change characterised by building on good practices, developing small scale trials, and continuous improvement is an inappropriate change model for Bromley. Rather, the overall model of care requires transformation to break what is an increasingly dysfunctional cycle.

5. FUTURE DEMAND IS UNAFFORDABLE, SOON

At a local level, consolidation of the health and social care five-year forecasts provided by Bromley CCG and LBB show an unaffordable funding gap by 2019/20.

In a 'do nothing' scenario, where no productivity and efficiency savings are made after 2015/16, and no action is taken to address the growing demand for services, the financial challenge to the economy (excluding Primary care) would be £72.3 million. This represents the difference between the available funding, forecast at £525 million, and projected costs of £597 million. It is likely that the gap may be larger should a reasonable growth assumption for primary care be factored in.



New models of whole-system working must be implemented in order to deliver the required productivity and efficiencies in health and social care delivery

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6. ICN co-design key conclusions

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7. BROMLEY RECOGNISES THE NEED FOR CHANGE

Through the stakeholder engagement sessions it was identified that Bromley is facing the following issues and solutions in the current model of delivering health and social care to its population.

1. Need to improve joined up working	• Multi-skilled workforce with task sharing • Community services to participate in GP practice meetings • Better care planning and communication within the community care system • Standardise assessments across community teams
2. Need to improve access to care	• Provide single point of access to care, or reduce number of access points • Map of available services for all staff to be aware of • Allow patients more direct access to services • Facilitate cross-organisation appointments
3. Need to improve care coordination	• Create a care cordinator role • Co-location of different community teams and services • Electronic shared integrated care records • Facilitate staff using shared care plans
4. Need to improve resource use	• Train patients to be more responsible for their own care • Train healthcare workers and district nurses to take on wider a wider range of functions • Create a central volunter 'hub' to improve awareness and access to local voluntary services • Better community 'signposting', directing patients to suitable care
5. Need to deliver proactive care	• Allow patients more direct access to services • More advance care planning • Greater staff focus on wellbeing and lifestyle • Provide a directory of services for patients
6. Need to improve care capacity	• Expand the rapid response service • Consider emergency placements in nursing homes • Improve community patient transport services • Improve support for carers • Commmunity pharmacies need to open longer, e.g on a rota • Improve response times, particularly for mental health

You have told us that there are specific improvement ambitions that centre on the need to reduce the amount of time people spend avoidably in hospital through better and more integrated care in the community, and increasing the proportion of older people living independently at home following discharge from hospital.

Evidence from patients, stakeholders, activity analysis, performance analysis, demographic analysis suggests strongly that a far reaching change in the out of hospital model is required.

In summary, you have told us that the system needs to address the following transformable mechanisms;

- Making the system more **proactive**
- Making the system more **co-ordinated** for people and professionals
- Making the right bits of the system more **accessible**

A system-wide OOH transformation would realise patient – related benefits through integration and efficient and productive delivery of care

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8. STAKEHOLDERS WERE BROADLY UNITED ABOUT FOUNDING PRINCIPLES FOR ICNs

The current model of care for OOH services in Bromley is a traditional model based around confined purpose organisations providing services on a needs basis. Commissioners and providers recognise the need for a shift to a new model of care to create balance and sustainability in the system.

In developing the strategy a set of design principles were drawn up and tested with the key stakeholders through the co-design process. The aim of these principles was to provide overarching structure and design to the design of the proposed model for OOH care.

CARE FUNCTIONS

The networks will form three functions:

- CO-ORDINATED CARE – (Providing patient centred, co-ordinated care and GP – patient continuity)
- PROACTIVE CARE – (Supporting and improving the health and wellbeing of the population)
- ACCESSIBLE CARE – (Providing a personalised, responsive, timely, flexible and accessible service)

OUTCOMES

The networks are responsible for providing consistent health and care outcomes for people across the population:-

- Quality
- Safety
- Value for money
- Performance / system usage

RESOURCES

Resources are aligned to need and location within the networks and this may include redistribution or refocus of resources – the structure will need to adapt to changing needs of the population

INCENTIVES

Providers will be incentivised individually and as part of a network, and will have accountability to deliver their contribution to the networks as a whole – this will change relationships between care providers.

CULTURE

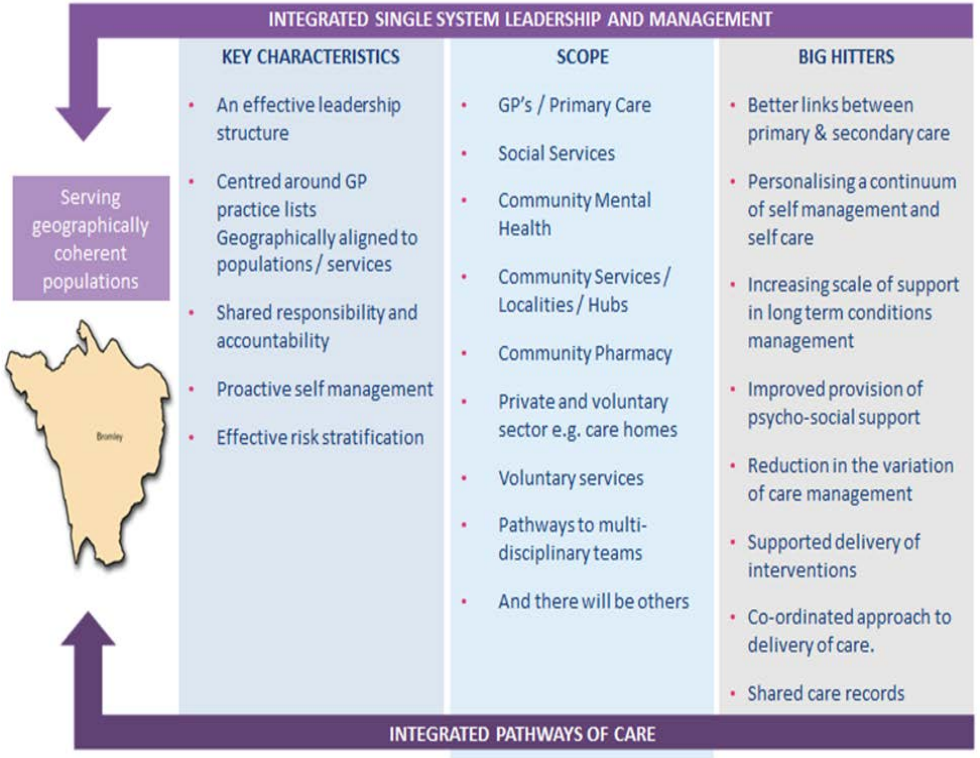
The responsibility and accountability of providers and commissioners is necessary to instil central and distributed leadership; There will be a commitment to shared values and behaviours around a customer focused culture - and an agreement to be measured and performance managed against these

9. INTEGRATED CARE NETWORKS REPRESENT A MECHANISM FOR TRANSFORMATION

It is envisaged that the proposed model of Integrated Care Networks should aim to make the system sustainable, easier for both professionals and people to use, encourage innovation and evolution and create a proactive culture of care for the population and health and social care providers.

Through the co-design process it was agreed that ICNs need to be credible to both the health and care professionals and the population they are serving, and as a result the ICN model:

- Will be centred around GP lists, as GPs practices hold the patient lists and are the clinical decision makers who take the ultimate responsibility for the health and wellbeing of the population.
- Contain, where appropriate, components of the secondary offer as well as other OOH providers.
- Need to support GPs practices, rather than the GP practices being the key coordinator of everything.
- Are not starting from nothing, as most parts of the system are there, albeit acting in silos.
- Will support the delivery of interventions and will share best practice.
- Will provide better links between primary and secondary care, i.e. geriatricians linked to GP practices in that community, and linking up with care homes.
- Will be geographically aligned to populations / services.



A new model of ICNs could transform the Bromley health and social care system; what Bromley requires is <u>not</u> a system of well-intentioned pilots and small nudges, but a significant re-gearing of focus and financial incentives towards implementing a new model of care.

10. THE PROPOSED MODEL OF CARE CAN TRANSFORM THE HEALTH AND CARE SYSTEM

The following table compares the key facets of the current model of care to those in the proposed new model of care.

CURRENT MODEL OF CARE	PROPOSED NEW MODEL OF CARE
Provider territory	Based on local networks of professionals and patients
Points of care based	Population based
Silo / pillar working	Integrated, person-centred care
Multiple access points	Single access points
Confined competency	Broader competency and task sharing
High variations in the provision of care provided	Standardised care model
Duplication of care activities	Streamlined working across boundaries
Condition management based on single morbidities	Case management based on the individual and their morbidities / risks
Pillar contracts for blocks of service activity	Block activity blended with risk and reward incentivised outcomes
Service based commissioning	Integrated commissioning
Provider risk management (incentivised to protect professional territory)	Provider risk sharing (incentivised to achieve population outcomes)
Acute demand centricity	Preventative care models
Short term	Medium to long term
Basic or absent care planning	Superior care planning
Reactive care	Primary and secondary prevention
Reablement limited to budget	Reablement on demand / need

The proposed new model of care derives from a need to move away from the current model of care in order to:

- **BENEFIT FROM ECONOMIES OF SCALE**: It may be possible to begin employing consultants or take them on as partners, bringing in senior nurses, consultant physicians, geriatricians, paediatricians and psychiatrists to work alongside community nurses, therapists, pharmacists, psychologists, social workers, and other staff.
- **MOVE THE PROVISION OF CARE INTO AN OUT OF HOSPITAL SETTING**: Over time here could be a shift of the majority of outpatient consultations and ambulatory care to out of hospital settings.
- **TAKE ON DELEGATED RESPONSIBILITY FOR MANAGING THE BUDGET FOR REGISTERED PATIENTS**. Where funding is pooled with local authorities, a combined health and social care budget could be delegated to ICNs.
- **UTILISE RESOURCES TO CHANGE BEHAVIOURS:** The ICNs would also draw on the 'renewable energy' of carers, volunteers and patients themselves, accessing hard-to-reach groups and taking new approaches to changing health behaviours.

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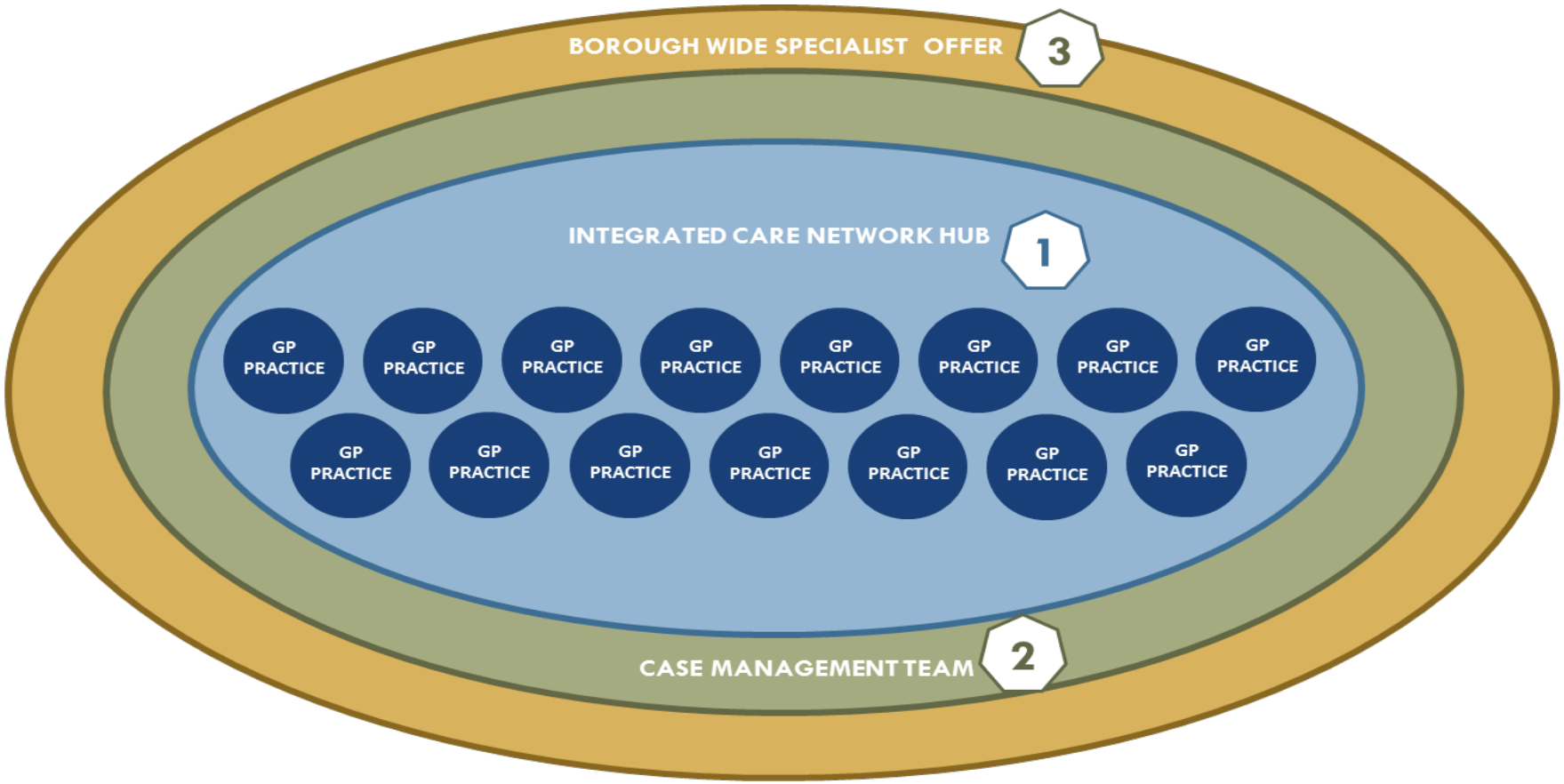
11. ICNs WILL OPERATE AT THREE LEVELS

The ICN model in Bromley will be delivered through a borough wide specialist offer and through the provision of ICN hubs. The following diagram provides illustration of how the ICN model will work in practice.



1 The **INTEGRATED CARE NETWORK HUBS** each serve a third of Bromley's population, with each hub comprising of a group of circa 15 GP practices covering a population of approximately 100,000 people., who are willing to work together, with 'dedicated' and 'specialist' networked support provided by the rest of the system.

2 The **CASE MANAGEMENT TEAM** within each hub consists of clinical care coordinators, clerical care navigators and a social prescribing advocate, who will work together and with the wider hub workforce to actively identify the target patient groups and their relevant needs; develop care plans to address their needs; case manage the delivery of the agreed care plans; and help both professionals and the public navigate the system in order to access the most appropriate care.

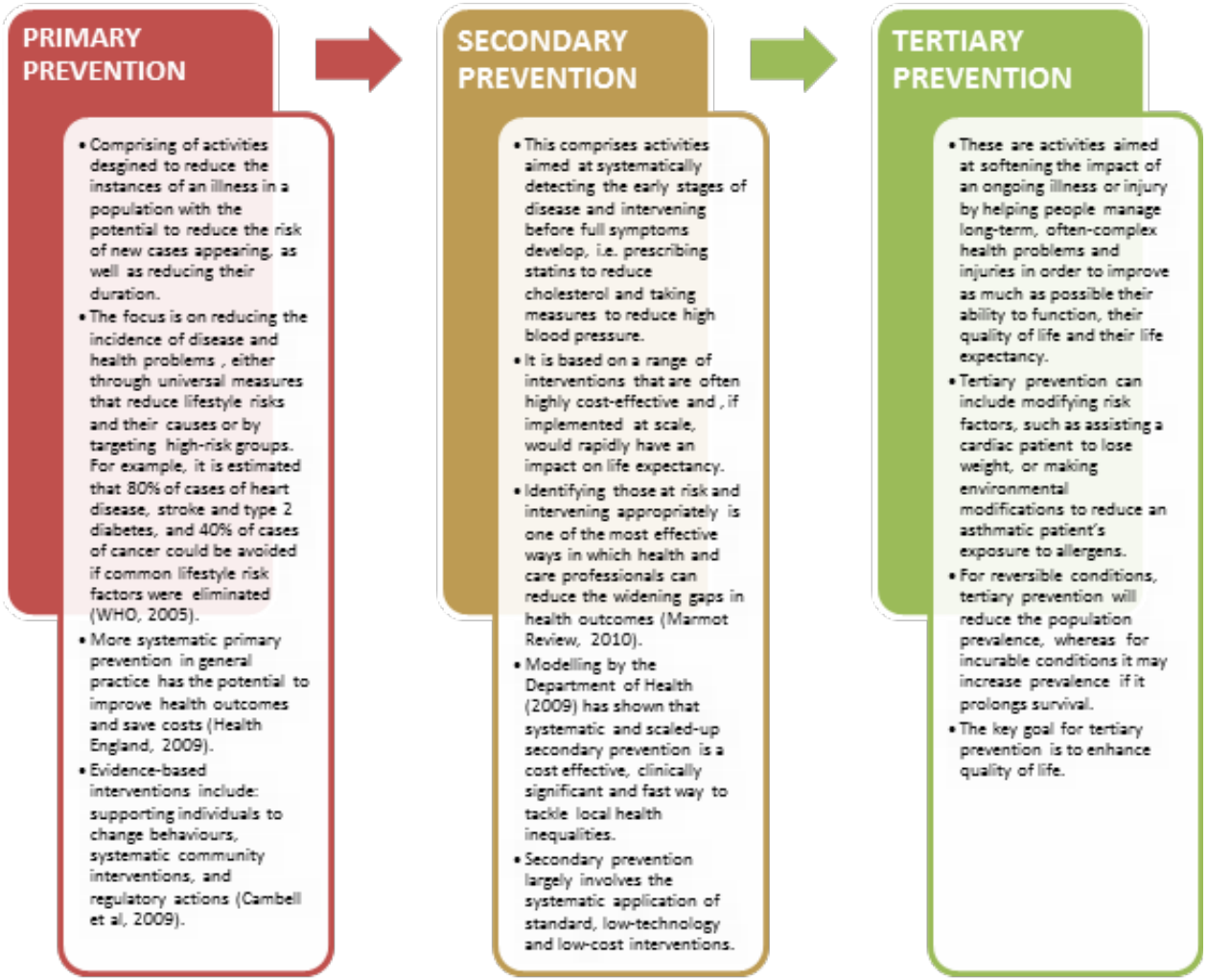
3 The **BOROUGH WIDE SPECIALIST OFFER** provides specialist and enabling services on a borough wide basis and will have a significant effect on access, coordination and proactivity. A key part of the integrated care networks is the interaction with acute consultants as well as the provision of care from other specialist health and care teams, such as the COPD team, direct reablement team and St Christopher's.

12. ICNs MUST HAVE A PREVENTATIVE CULTURE AND APPROACH

ICNs in Bromley will need to be proactive and ambitious in preventing ill health and escalation of demand. ICNs can play a significant role in ill-health prevention and public health, while at the same time improving continuity of care and reducing avoidable system usage. The proposed Hub based approach is therefore essential in developing efficient and cost effective preventative approaches.

ICNs will also play a key role in secondary prevention, whilst linking strongly to other capabilities (for example in public health and the PRUH) to support primary and tertiary prevention.

The following diagram outlines the three types of prevention the ICN model will need to consider



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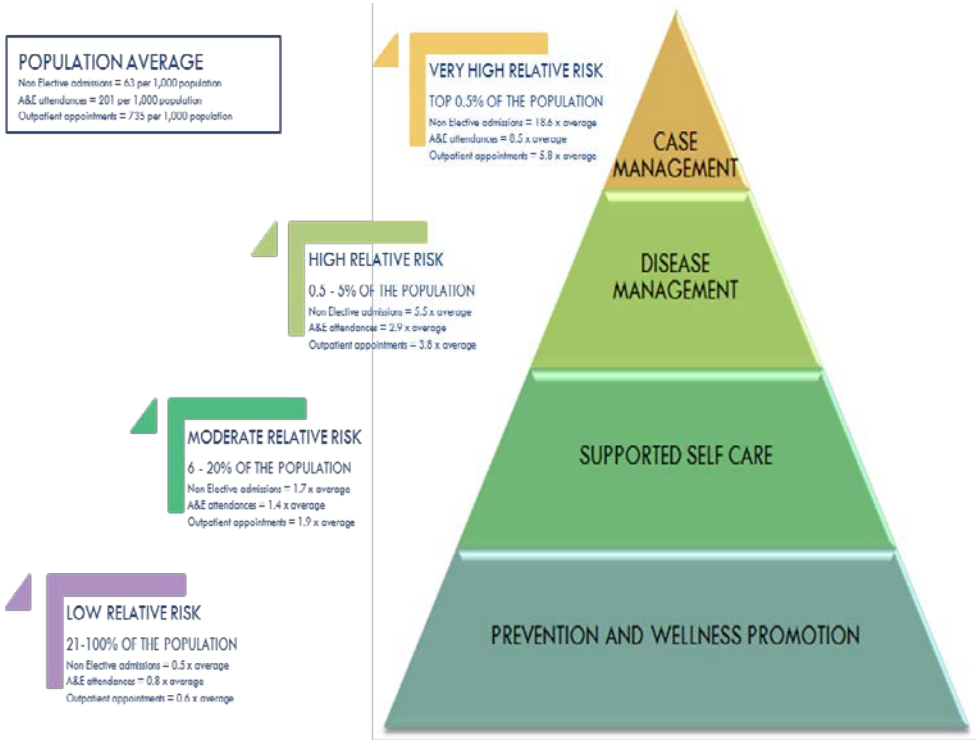
13. ICN'S WILL ENABLE HEALTH AND SOCIAL CARE TO SEGMENT AND TARGET THE POPULATION NEEDS

Non elective acute care has been increasing steadily and is now deemed unsustainable. The lack of consistent joined up care in the community has rendered patients with LTCs, particularly the frail elderly, vulnerable to exacerbations resulting in a higher numbers of admissions, length of stay and delayed discharges.

The commissioners in Bromley need to take urgent and sustained action to make integrated care and support happen over the next few years. Person-centred coordinated care and support is key to improving outcomes for individuals in Bromley who use health and social care services.

A risk stratification approach to the ICNs will provide an understanding of population need and service utilisation more effectively from a whole systems perspective, moving away from silo approaches that are disease or programme based.



The ICNs will enable the health and social care professionals in Bromley to introduce different initiatives around each of the risk categories in the pyramid to prevent people from moving up the pyramid and potentially requiring a greater level of support. By multidisciplinary team working and anticipatory care planning, integrated teams can align all necessary preventative interventions efficiently and economically as early as possible to prevent the 'crisis' from happening.

Multi-disciplinary working through ICN's will wrap around the hubs, operate virtually and be at a scale that creates benefits and allows the system to offer more dedicated support.

Targeting people with long term conditions will be a priority and through enabling the co-design of a specialist network with secondary and other specialist, that provide specialist and enabling services on a borough wide basis.

14 CASE MANAGEMENT AND CARE CO-ORDINATION WILL PROVIDE COLLABORATIVE AND CONSISTENT APPROACHES TO CARE PLANNING

It is envisaged that ICN's will be comprise of some of the following components;

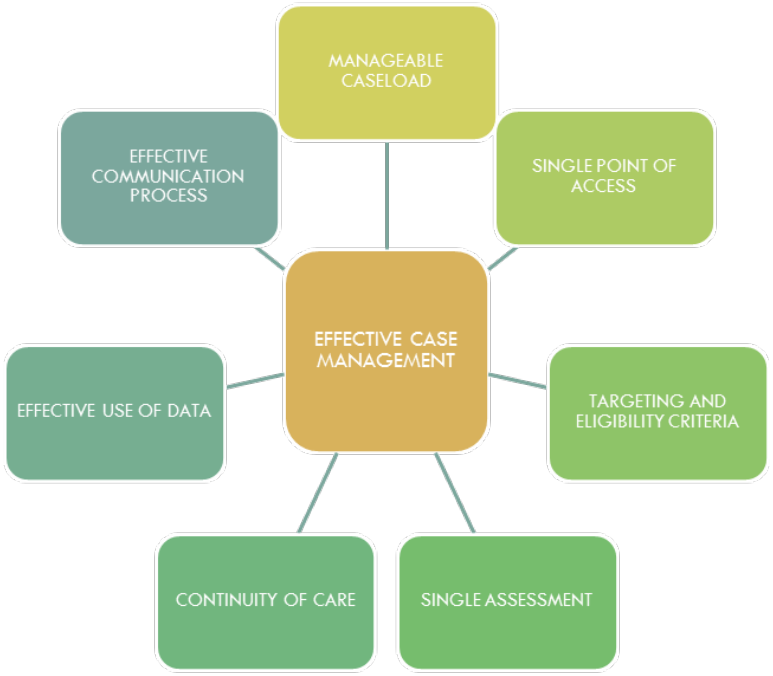
SINGLE POINT OF ACCESS

The SPoA will enable a better entry into the Bromley health and care services, as well as better access to services, driving up standards of quality care, and a total commitment to improving the patient experience. This SPoA will also potentially be a direct link to the transfer of care bureau whereby discharge summaries will be sent to each ICN where they will be screened for keywords such as 'respiratory' or medicine names that are in line with relevant condition and then channeled through the relevant pathway.

THE CASE MANAGEMENT TEAM

Case management is the process of planning, coordinating and reviewing the care of an individual and can be used to co-ordinate patient care. It usually involves a combination of core elements including assessment, planning, linkage, monitoring, advocacy and outreach. The Case Management Team would comprise of;

- **Clinical care coordinator** - A newly formed role within each ICN that builds upon the current community matron role and promotes a more holistic and targeted function.
- **Clerical care navigator** – A newly formed role cited in best practice as a fundamental resource that overcomes barriers and improves access for individuals in the health and care system in Bromley.
- **Social prescribing advocate** - A newly formed role within the ICN that operates closely with GP practices and the case management team to identify and target individuals who would benefit from a form of social prescribing



AN INTEGRATED CARE NETWORK WORKFORCE

The OOH strategy will be delivered in the main through the ICNs which will integrate the current Bromley Healthcare, Oxleas and LBB teams, expanding and enhancing the current services to become more streamlined and effective.

Each ICN will have a constant named workforce based on the existing teams who currently provide the health and social care provision in Bromley:

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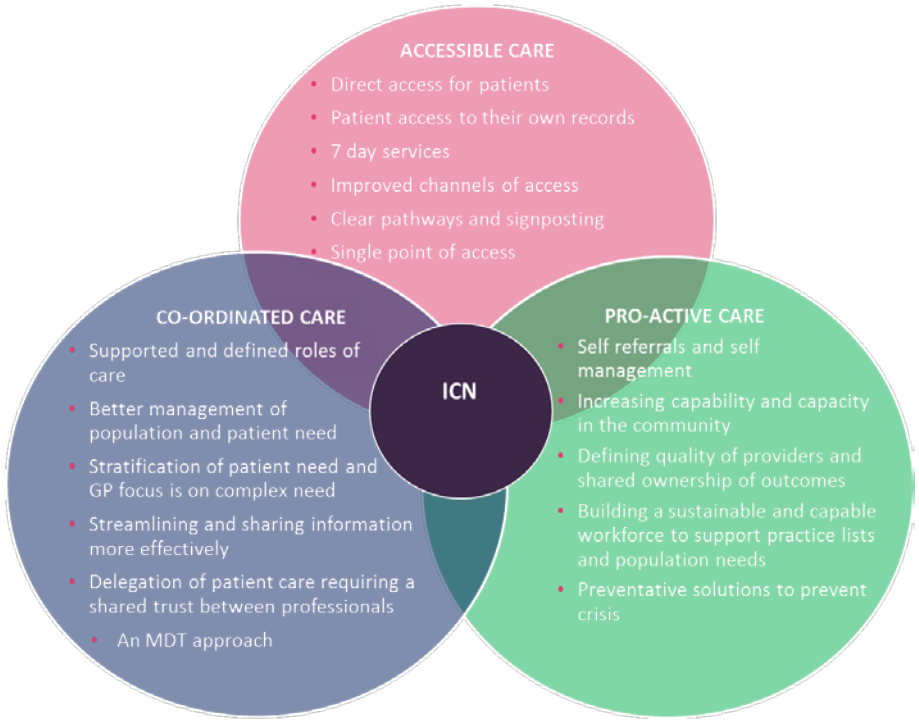
15 VOLUNTARY AND COMMUNITY SERVICES ARE FUNDAMENTAL IN THE DELIVERY OF PROACTIVE, ACCESSIBLE AND CO-ORDINATED CARE WITHIN THE ICN MODEL

VOLUNTARY AND COMMUNITY SECTOR

It is understood from discussions with the VCS providers that there is already a clear commitment to forming a consortium / formal partnership of major local VCS providers to deliver the strategy, which will provide the following additional benefits to the delivery of the ICNs:

- Having a **single contract** for all the VCS activity commissioned as part of the new ICN model.
- A single representative from the VCS on the appropriate Board for each ICN, taking shared responsibility for delivery of collective outcomes on behalf of the VCS.
- Quality and value for money benefits from having the VCS making a direct contribution to a whole system model of healthcare.
- Encompassing the 'patient voice' and helping people connect about health and wellbeing issues that are important to them, their family and their community.
- True integration with all key providers from the third / voluntary sector.



COMMUNITY PHARMACISTS

It is envisaged that as part of the introduction of the ICN model in Bromley, the CCG and the council will commission community pharmacists to provide the wider ranging services detailed above in order to make services more accessible for the population, reduce pressure on the urgent care system, and free up capacity for other health and social care professionals.

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