London Borough of Bromley

PART ONE - PUBLIC

HEALTH AND WELLBEING BOARD

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Report Title: **Integrated Care Networks update**

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1. SUMMARY

The purpose of this paper is to provide an update on progress with the implementation of Integrated Care networks (ICNs) in Bromley including the mobilisation of the first two new pathways, namely the Proactive Care and Frailty Pathways.

The Proactive Pathway was mobilised at the end of October 2016 and good progress has been made with weekly integrated Multidisciplinary Team meetings (MDTs) now happening across all three networks. Since the last report to the Health and Wellbeing Board in November 2016, the CCG have received a report from Providers on the first 100 patients to go through the Proactive Care pathway. While it is too soon to assess the full impact of the pathway there have been positive case studies. A dashboard is being developed to monitor patient activity before and after the patient enters the Proactive Pathway, this dashboard will be monitored via the ICN steering group. An independent quantitative and qualitative evaluation of the ICN Proactive Pathway has been commissioned by the CCG and is being undertaken by the Health Innovation Network (HIN), with a final report expected to the CCG in July 2017.

The related Primary Care Local Incentive Scheme (LIS) for Integrated Case Management has been useful in encouraging GPs to identify and refer patients to the new proactive pathway. This scheme is being extended for six months to September 2017 to ensure no gaps and to coincide with the new contract for Primary Care.

Following the sign off of the NEW Frailty pathway, good progress has been made with mobilising the hospital end of the pathway. New wards have been designed and opened by KCH, this happened despite a challenging timeline, challenging recruitment trajectory and winter pressures. The NEW Churchill Ward in Orpington Hospital opened at the beginning of January 2017, followed closely by six more beds on the NEW Elizabeth Ward which is collocated as part of the new integrated frailty facility. Although there are still some ongoing recruitment challenges with nurses and Consultant Gerontologists, a full service multidisciplinary team is in operation including the new post of Care Navigator Manager employed by Age UK. The full frailty pathway implementation is scheduled for completion this month with rapid access clinics becoming available and the opportunity for patients to

be admitted directly to these wards from the community via the Gerontology Hotline. It should be noted that there is a chance that this timeline will slip because of consultant capacity; however the CCG will be continuing to work closely with KCH with the aim of getting to full pathway mobilisation as soon as possible.

A key enabler to ICNs progress to date has been the current MOU the CCG put in place with system providers. The MOU runs until September 2017, as such, the CCG will need to review and agree either a refresh of the MOU, or consider some type of alliance contract with Provider based on national templates. This work will need to start from April to ensure no gap in current arrangements.

Due to a small slippage in recruitment there is currently an underspend of £53k against the profiled plan. The Provider Joint Operating Group is forecasting an 'on plan' position by September as a result of catch up MDTs being arranged in May, June and September. Allocation of resources to cover the fiscal year end is being agreed with BHC finance.

At this stage there is no reason to assume the performance metrics will not be met so the performance fund is expected to be spent.

The ICN Board is now looking at the 'next steps' for the networks in providing integrated care to patients in Bromley. A highlights paper was circulated at the Bromley CCG Clinical Executive Group on 2nd March which included the proposal for new strategic system project areas, these included:

- Care Homes (Building on current CCG work)
- Urgent Care (Admissions)
- Integrated Discharge (Therapies)
- Integrated Heart Failure service

The focus now will be as follows:

1. To complete mobilisation of Proactive and Frailty pathways, continuing to monitor progress, continue to learn and improve with the overall aim of embedding into business as usual.
2. To work with the system providers to initiate the new workstreams and build any associated business cases and project plans
3. To review the MOU with Providers ahead of September and agree governance / alliance contract arrangements going forward.

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2. REASON FOR REPORT GOING TO HEALTH & WELLBEING BOARD

To provide an update to the Health and Wellbeing Board on progress to date with the development of ICNs and the Proactive and Frailty Pathway implementation, and to note the proposed focus for the coming months.

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

The Board is asked to note the content of the paper for information.

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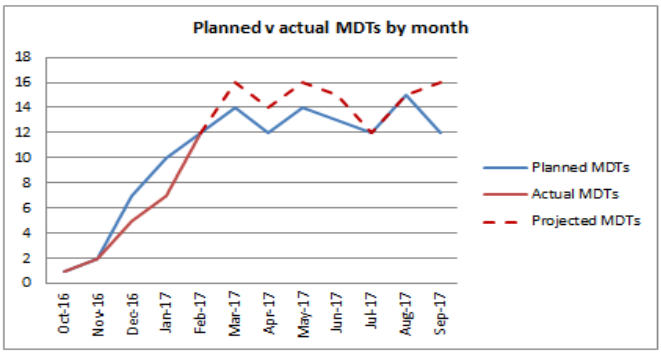
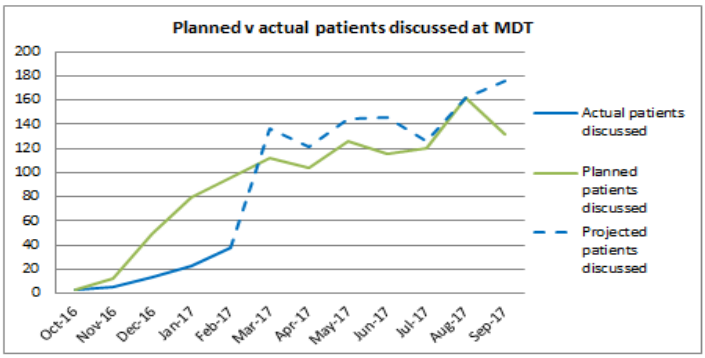
4. COMMENTARY

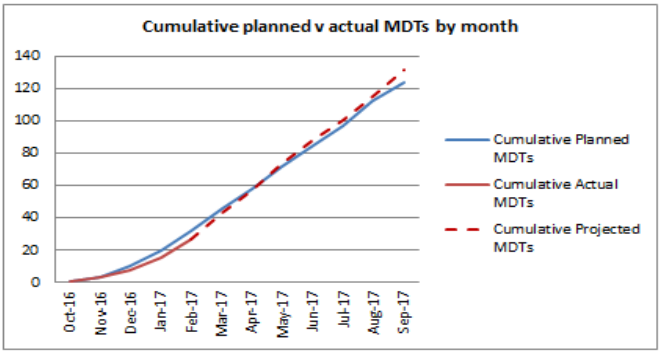
In May 2016, a Memorandum of Understanding was signed between Bromley Clinical Commissioning Group and local providers – King's College Hospital NHS Foundation Trust, Bromley Healthcare Community Interest Company, Oxleas NHS Foundation Trust, Bromley GP Alliance, Age UK Bromley and Greenwich, St Christopher's Hospice and the newly formed Bromley Third Sector Enterprise.

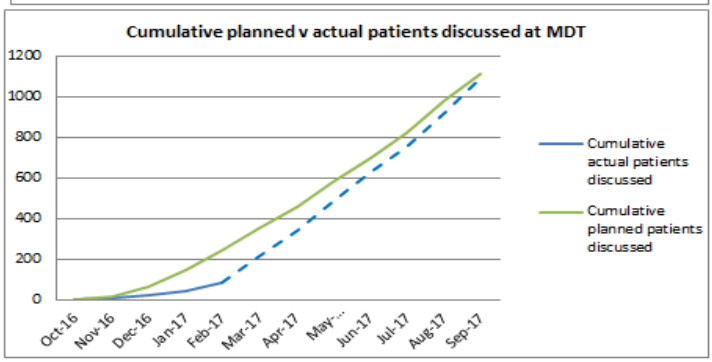
Following development of the Proactive Care Pathway, the first MDT meeting was held in October 2016. The Providers formed a Joint Operational Group (JOG) with representatives from all organisations overseeing the operational performance of the new Proactive Pathway. The JOG reports to the ICN Steering Group chaired by the Chief Officer of the CCG, it is through this governance that the CCG can be assured of the progress and impact of the new proactive pathway.

Since then, over 100 patients have been through the pathway. Availability of MDTs was fully established at 3 per week (1 per ICN) in February with a corresponding increase requested for referrals.

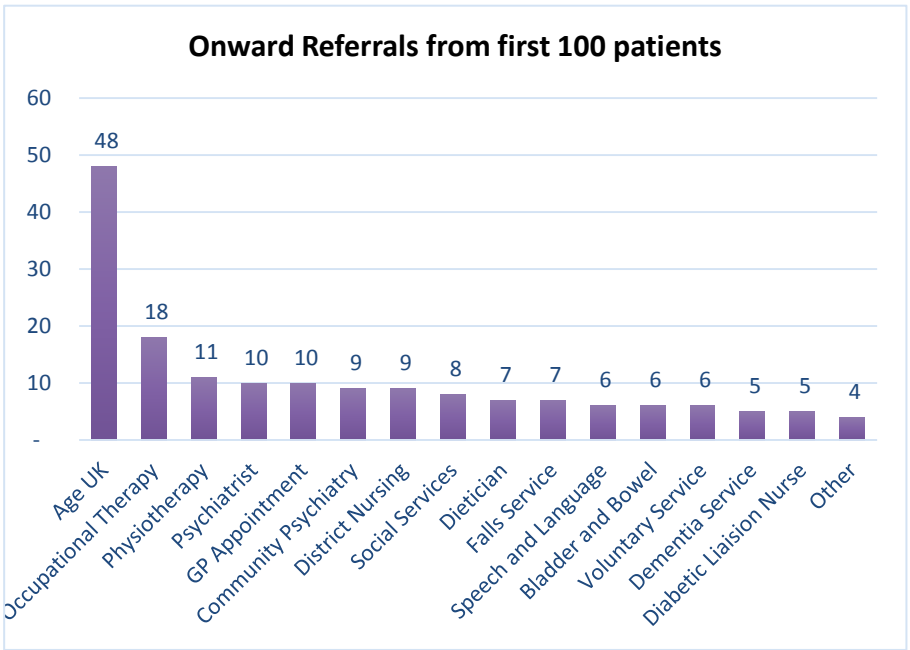








The outcome we can report immediately is the follow-on actions for each patient after their comprehensive Community Matron Assessment has been discussed at the MDT meeting. A report on the first 100 patients through the pathway reveals some 48 have been referred on to Age UK for additional support, 35 referrals to a community therapy service and 24 referrals in to mental health services. Only 8 referrals were made to Social Care.



CASE STUDY 1: "SG"

"SG" is a 59 year old male known to the community mental health team. He has had a series of emergency calls to 111 and visits to the PRUH Emergency Department. A visit to the patient showed that home

hygiene is compromised, he is struggling to survive on benefits and his home was cold through lack of heating.

Advice was given on benefits and the need to maintain provisions e.g. buy non-perishable items. Contact was made with a food bank to provide assistance, EDF energy to place credit on his meter and credit was added to his Oyster card to enable him to travel to planned medical appointments.

In the six weeks before the MDT intervention, SG had called 111 on 16 occasions and visiting A&E 4 times. Six weeks after there have been no emergency contacts.

CASE STUDY 2: "CS"

"CS" is a 74 year old female currently receiving reablement following an inpatient episode. She lives alone in an upper floor flat. Her carer is a friend but she doesn't live nearby.

She has a complex history of severe COPD (known to Community Respiratory team), Ischemic Heart Disease and confusion. Oxygen was prescribed but later removed on safety grounds. In the last two years she has had an acute myocardial infarction and breast cancer. She will not accept support with personal care, is non-compliant with medication and refuses to attend a memory clinic.

Actions include memory assessment, establishment of power of attorney with next of kin, a social care package following reablement, review from Medicine Optimisation Service, and oxygen re-established following disconnection of unused gas cooker. Bromley Care Coordination are now providing support.

Medicine compliance is now greatly improved resulting in a reduction in calls to primary care. Measures are now in place to prevent secondary care admission.

Update on the new facility at Orpington Hospital

Regarding Frailty – joint governance arrangements were put in place with KCH, these continue with a Frailty Programme Group. Reporting into the Programme Group is the Clinical Interface Group (formed in August 2016), this is now a bi-weekly meeting which works as a key vehicle for driving implementation on the Frailty pathway.

This pathway was signed off at the ICN Board and CCG Clinical Executive Group in December 2016 and included the following:

- Gerontology Hotline providing advice and guidance to Bromley GPs
- A new 38 bed sub-acute facility at Orpington Hospital
- Hot Clinics at PRUH
- Chair Clinics at Orpington

The Orpington Integrated Unit consists of two wards, Elizabeth and Churchill with 38 beds / chairs. Churchill opened on 5th January 2017, with the first six beds in Elizabeth following the week after. Opening of further beds in Elizabeth has been delayed due to problems with recruitment. It is expected that this is resolved by the end of March with the facility expecting to be fully open including the acceptance of 'Step Up' admissions from the community.

A Standard Operating Procedure for the unit was signed off at the Frailty Programme Group in February 2017.

A dashboard has been developed that monitors admissions source, patient demographic, length of stay (in Orpington), discharge destination and any onward (re)admission to PRUH required. Further

work is being undertaken to include Care Navigator Manager outcomes and standard quality indicators specific to these wards e.g. Friends and Family, Pressure Ulcers, etc.

Summary of issues / risks and actions / mitigations taken to minimise these

Now the unit is open and operational, risks are being managed by King's as part of the integrated governance structure. However, the Clinical Interface Group is continuing to meet fortnightly to cover the remaining elements of the pathway. Also, the CCG is continuing to be involved in the post implementation meetings that are monitoring the operational performance of the new facility.

Recruitment of qualified nurses and Consultant Gerontologists remains a risk, with high bank and agency usage.

Public and User Involvement

Patient Advisory Group ("PAG") members participated in a Frailty Workshop held at The Warren on 9 May 2016 where they had the opportunity to contribute to the initial thinking around the Frailty Pathway.

In August 2016, a written update was provided to the PAG members to advise them of the ongoing work in developing a Frailty Pathway that is linked to the ICN model of care, and that helps to support the frail elderly population of Bromley in a more integrated and coordinated way, both in and out of hospital.

A Patient Frailty Focus Group was held on 28 November 2016 and was attended by PAG and Healthwatch members. The purpose of this session was to discuss and test key aspects of the new Frailty Pathway to ensure the patient voice has been considered in the frailty pathway and that it is fit for purpose. Kelly Scanlon, CCG Head of Communications and Engagement is currently developing a patient FAQ document that answers the questions raised in this session.

Following the opening of the beds on the Orpington site, King's held a Public Information event at Bromley Baptist church earlier this month, which was attended by more than 50 patients, carers and members of the public.

5. FINANCIAL IMPLICATIONS

The financial envelope agreed for the ICN Proactive Care and Frailty Pathways is on plan. As plans are developed for the next system strategic projects it is anticipated that investment of 'pump – prime' money may be required. These will be worked up and presented to Clinical Executive for consideration as they are made available, either directly as part of an ICN update or via the QIPP Planning and Delivery Group report.

6. LEGAL IMPLICATIONS

None identified.

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

None identified.

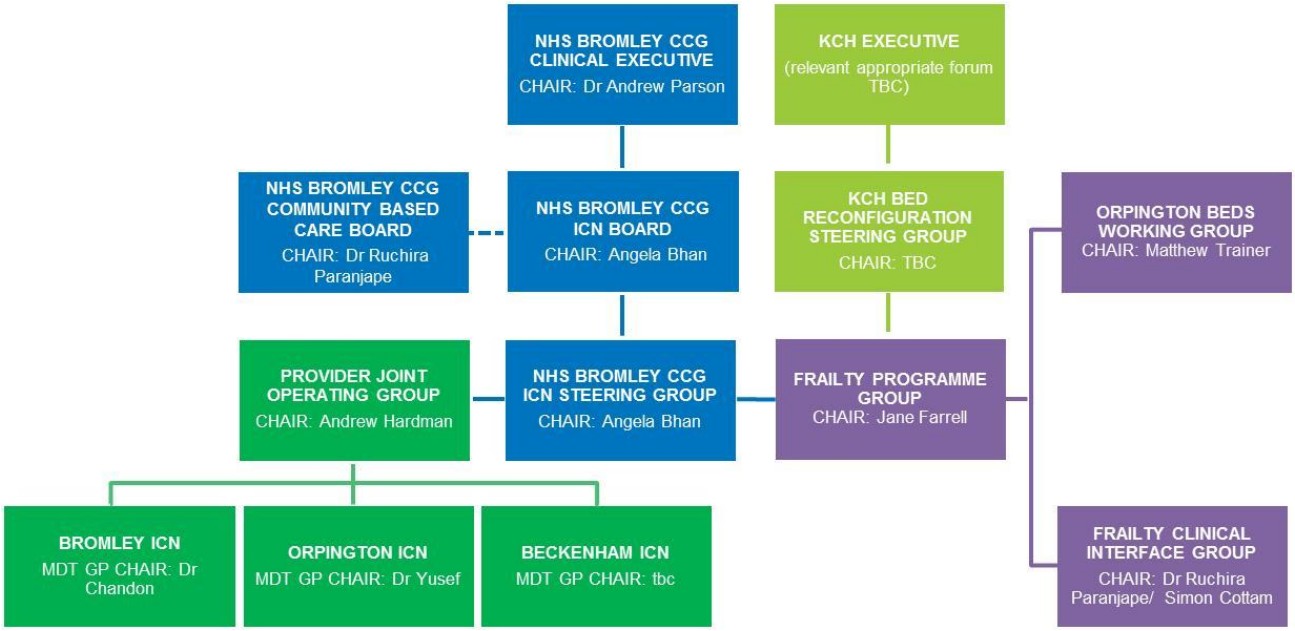
Proactive Care is managed by the Provider Joint Operating Group which reports to the ICN Board via the ICN Steering Committee.

The development of the Frailty Pathway has involved weekly Frailty Clinical Interface Group meetings which include representatives from KCH, the CCG, Oxleas, BTSE, the GP Alliance, St Christopher's,

Bromley Healthcare and LBB. These meetings are now fortnightly to complete the rest of the pathway following the opening of the beds.

The Frailty Clinical Interface Group reports into the Frailty Programme Group, as part of joint governance arrangements which have been put in place with KCH (PRUH). The Frailty Programme Group met on 8 December 2016.

The Frailty Programme Group reports into the ICN Board. An update was provided at the recent meeting on 16 February 2017.



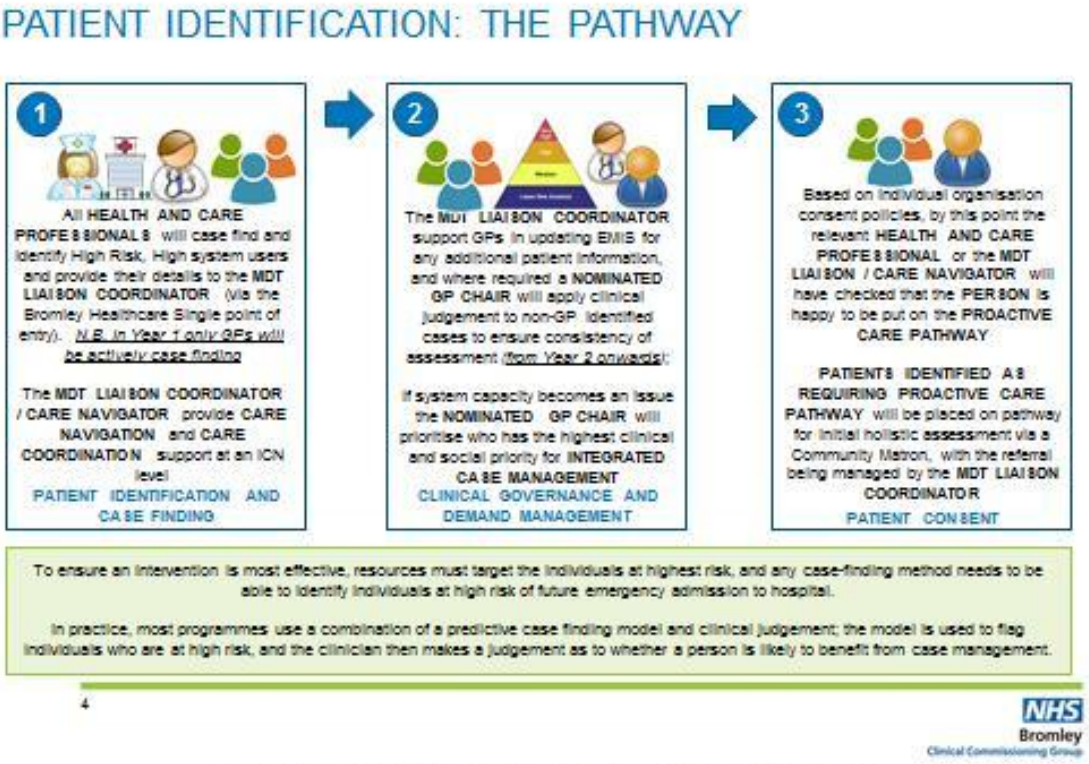
8. COMMENT FROM THE DIRECTOR OF AUTHOR ORGANISATION

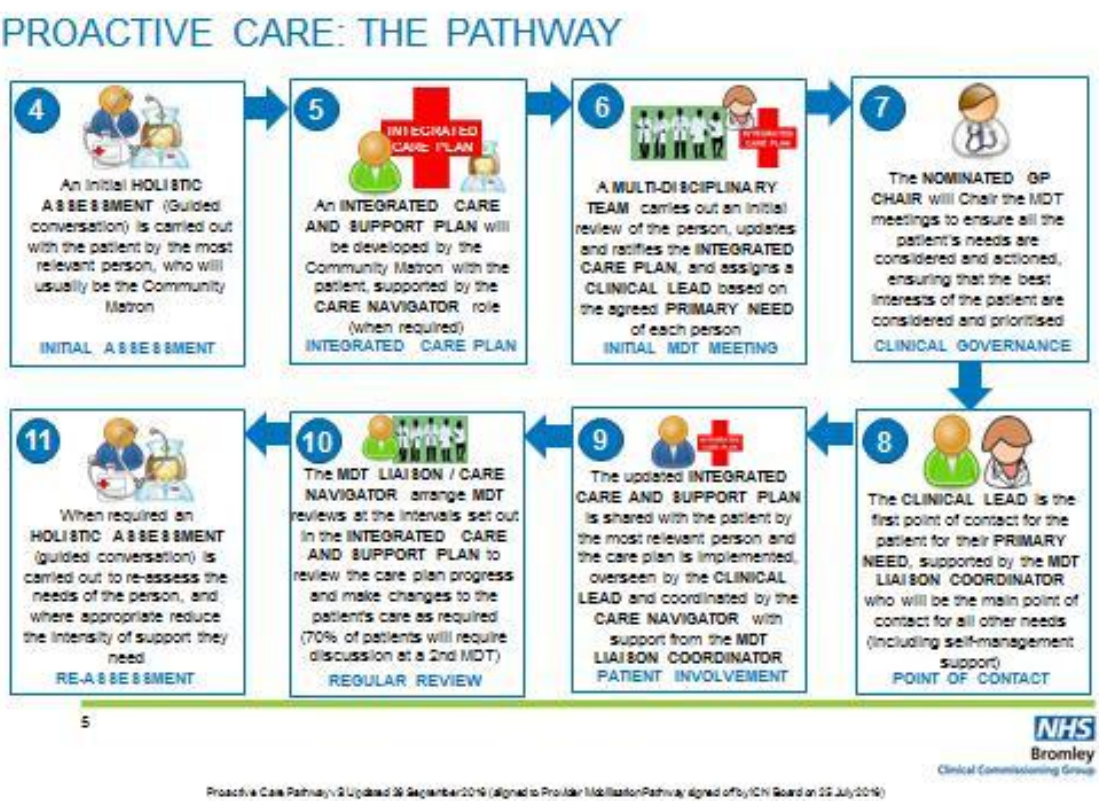
Significant progress has been made on the two early pathways developed through the ICN Model. The challenge now is to embed these pathways and build on the integration of providers to deliver more seamless care for patients in Bromley.

Mary Currie, Interim Director of Transformation, NHS Bromley Clinical Commissioning Group

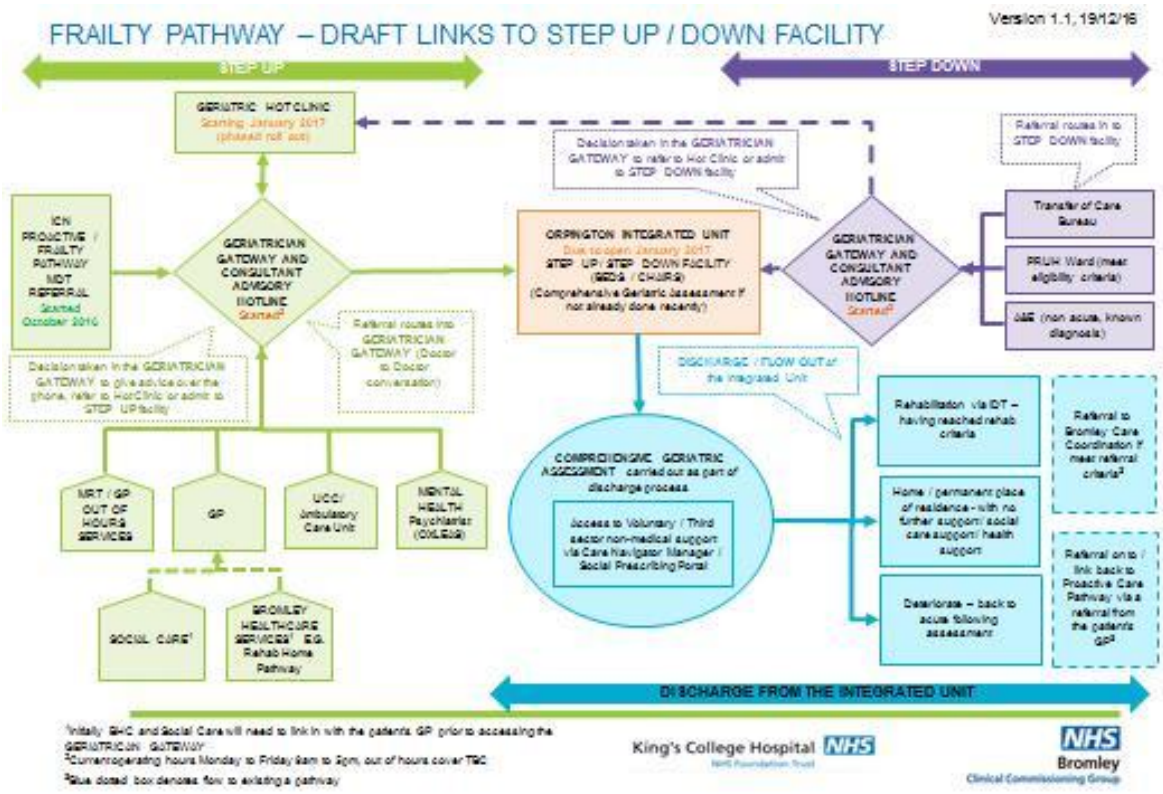
Non-Applicable Sections:	[List non-applicable sections here]
Background Documents: (Access via Contact Officer)	[Title of document and date]

APPENDIX 1 – PROACTIVE CARE PATHWAY





APPENDIX 2 – FRAILTY PATHWAY



FRAILTY PATHWAY – ELIGIBILITY CRITERIA TO STEP UP / DOWN FACILITY

KEY REQUIREMENTS

- Non-acute elderly care
- Patients whose condition is likely to require some medical input
- Level of Frailty: scoring at least 6-7 on the Rockwood Frailty Scale (age not deciding factor)
- Hours of decision making for referrals: proposed 8am-5pm based on availability of Geriatrician
- Patients with a Bromley GP (test impact after 2-3 months)
- Access – via step up or step down through Geriatrician gateway
- Unit is consultant led with a MDT approach - TBC
- 7 day access

STEP UP

- Referral through one of the following Gerontology gateways:
  - Geriatrician hot clinic
  - MDT referral from Proactive Pathway
  - GP referral via geriatric hotline where patient has been suitability assessed as not requiring admission to acute site
- Patients with known diagnosis or ongoing needs but cannot be treated at home, requiring a stay of less than in the region of 7 days
- Patients with delirium or dementia who require non-acute support can be discussed and considered for this support
- Step up via Rehab Home Pathway or MRT for patients who are not safe to be supported at home and require inpatient rehabilitation
- Management of venous ulcers and patients with long term conditions that have been gradually failing with an identified cause e.g. increased leg oedema
- People discharged, where the package of care is inadequate or there was a non-acute reason for the package of care not being supportive (recurrent admissions)

STEP DOWN

- All step down patients will have had a Comprehensive Geriatric Assessment started before transfer
- Recuperation/rehabilitation for patients whose condition is not currently reaching Lauriston criteria (slow stream)
- People who are medically stable but require support because their carer has been admitted
- Minor illness and falls not covered by the current fracture pathway
- Resolving Delirium / Dementia (slow stream requiring longer length of stay) - TBC

Version 1.1 'Go Live', 19/12/16
Frailty Clinical Interface Group

NHS Bromley Clinical Commissioning Group