Report No.
Not Applicable
(CCG report)

London Borough of Bromley

PART 1 - PUBLIC

Decision Maker:	**HEALTH SCRUTINY SUB-COMMITTEE**
Date:	**13th June 2017**
Decision Type:	Non-Urgent Non-Executive Non-Key
Title:	**INTEGRATED CARE NETWORKS - EARLY IMPACT REPORT**
Contact Officer:	Mary Currie, Interim Director of Transformation, NHS Bromley Clinical Commissioning Group Tel: 01689 6866542 E-mail: mary.currie3@nhs.net
Chief Officer:	Dr Angela Bhan, Bromley Clinical Commissioning Group
Ward:	Borough-wide

1. Reason for report

1.1 To provide an update on the early impact of Integrated Care Networks.

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2. RECOMMENDATION

2.1 The Health Scrutiny Sub-Committee is asked to note the progress made on Integrated Care Networks.

Impact on Vulnerable Adults and Children

1. Summary of Impact: Integrated Care Networks will provide support to vulnerable adults and children.

Corporate Policy

1. Policy Status: Existing policy. NA
2. BBB Priority: Supporting Independence. Healthy Bromley.

Financial

1. Cost of proposal: N/A
2. Ongoing costs: N/A.
3. Budget head/performance centre: NHS Bromley CCG
4. Total current budget for this head: £N/A
5. Source of funding:

Staff

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

Legal

1. Legal Requirement: Non-statutory – Government guidance
2. Call-in: Call-in is not applicable. No Executive decision.

Customer Impact

1. Estimated number of users/beneficiaries (current and projected): TBC

Ward Councillor Views

1. Have Ward Councillors been asked for comments? N/A
2. Summary of Ward Councillors comments: N/A

3. COMMENTARY

3.1. 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. The key aim was to commit to working together to establish a new model of care, in the form of three new Integrated Care Networks (ICNs) for the Bromley population and to co design, mobilise and agree delivery trajectory for new pathways within the ICNs.

3.2. The first pathway to mobilise was the Proactive Care Pathway, a key element of this pathway is multidisciplainary (MDTs) meetings which include key professionals from each organisation e.g GP, Community Matron, Consultant Gerentologist, care navigator and mental health professional. The first MDT meeting was held in October 2016. In terms of governance 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 and Board, chaired by the CCG Chief Officer, it is through this governance that the CCG can be assured of the progress and impact of the Proactive Pathway.

3.3. Since October, over 250 patients have been through the pathway. The CCG is formally monitoring progress and impact on a monthly basis. There has been a positive trend of month on month increases in the number of patients being identified by GPs and going through the MDTs, in all three networks. In addition to looking at activity and formal reporting we are also capturing informal feedback to help maintain a focus on continuous improvement. Positive stories coming through from health professionals include feedback on the the value of the discussion taking place at the MDT and the positive actions/outcomes for patients. We are working to develop a pipeline of case studies to maintain a very patient outcomes focused approach.

3.4. Below are two case studies of patients identified as part of a review of the first 100 patients through the pathway:

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.

CASE STUDY 3: "PB"

"PB" is a 91 year old female presenting with multiple issues including angina (ischaemic heart disease), increasing episodes of falling , cognitive impairment with reduced hearing and vision (registered severely sight impaired) and deteriorating memory.

She lives alone with carer support. Due to decreased mobility she sleeps downstairs. A zimmer frame has been provided but standing capacity is poor. Mobility is further comprised through knee pain due to osteoarthritis and callous on her heel from a longstanding pressure ulcer. Additional equipment includes a riser recliner chair with pressure relief and provision of a commode. A carer attends 5 times/week and the family complete shopping tasks.

PB adheres to her medication regimen but does not understand why she is taking all her medication. PB requires assistance with chair / bed transfers and with personal care tasks washing and dressing and toileting. PB has a persistent dry cough.

Actions include the District Nurse reviewing pressure sores and completing ear syringing, referrals to the Falls Team and Memory Clinic, Community Physio to review mobility and discuss further aids with Community Matron. Drugs reviewed by the Gerontologist and a rapid access medical review organised with Cardiology. The patient is now under the care of St Christopher's and Age UK are providing support.

Feedback received from the patient's daughter (and carer):

"I can't thank you enough for everything you have done for my family. It was such a relief for me personally to be able to hand over the management of mum's various problems to someone knowledgeable and competent, instead of travelling through unfamiliar territory on my own when much was at stake for us. With kind regards and gratitude."

3.5. Performance against targets set out in the Memorandum of Understanding that underpin the provider performance fund will be analysed and reported to the ICN Steering Group in June.

3.6. An independent review of the ICNs has been commissioned by the CCG from the Health Innovation Network (HIN), with a final report to be delivered to the ICN Steering Group in September. This review includes data analysis, questionnaires and interviews with health and social care professionals, as well as feedback from patients/carers of their experience of being on the pathway.

3.7. Data sharing agreements are now in place between health providers, social care and the voluntary sector to support the delivery of more joined up care for patients. Work is being undertaken to track patient interaction across the health and social care system, looking at the six months before and after the Proactive Care MDT. This information will provide a rich intelligence on the impact of the pathway at both an individual and service level.

3.8. Priorities for the next phase of ICN pathways are being developed through the Bromley System Leaders Programme (where all Providers and LA senior leaders are participates). There are currently four new workstreams being explored, with an assessment of progress to date at a meeting on 27 June. The workstreams being explored are: Care Homes(includes Nursing homes etc…), with a focus on reducing emergency admissions; acute admissions at end of life; integrated therapy services, with the aim of ensuring more joint up working between professional groups to support effective, high quality discharge of patients back to their place of residence; and integrated heart failure services, aiming to reduce the number of readmissions with relapses in the patients condition and explore a more community facing service.

4. PERSONNEL IMPLICATIONS

4.1 Supports more integrated working of professional to enable better delivery of joined up care. No negative implications.

5. POLICY IMPLICATIONS

5.1 Aligned to national policy including the NHS Five Year Forward View and GP Forward View.

6. FINANCIAL IMPLICATIONS

6.1 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 Bromley CCG Clinical Executive Group for consideration, either directly as part of an ICN update or via the QIPP Planning and Delivery Group report.

Non-Applicable Sections:	Legal Implications.
Background Documents: (Access via Contact Officer)	N/A