Report No.
CEO 18003

London Borough of Bromley

PART 1

Decision Maker:	**CONTRACTS & COMMISSIONING SUB-COMMITTEE**
Date:	**17 July 2018**
Decision Type:	Information
Title:	**Joint Commissioning Update – Bromley Council and Bromley Clinical Commissioning Group**
Contact Officer:	Paul Feven and Graham Mackenzie, Interim Joint Directors of Integrated Commissioning, Paul Feven - Tel: 020 8461 7440 e-mail: paul.feven@bromley.gov.uk Graham Mackenzie - Tel 0203 930 0100 e-mail graham.mackenzie1@nhs.net
Chief Officer:	Paul Feven, Interim Joint Director of Integrated Commissioning, ECHS
Ward:	All

---

1. Reason for report

1.1. The report offers the Contract Sub Committee an update on joint commissioning activity between the London Borough of Bromley and Bromley CCG.

---

2. Summary

2.1. This report provides an update on joint commissioning activity between the council and the CCG. The report is structured around the work programme of the Integrated Commissioning Board (ICB), the integrated officer governance body for health and social care.

2.2. Set out below is an outline of each strand of the work programme.

3. Integrated Commissioning Board work programme

3.1. **Integrated governance**

3.1.1. The Integrated Commissioning Board emerged from a review of health and social care governance in 2017. The ICB is intended to strengthen the commissioning approach across the Borough to ensure public funds are utilised in the best way possible,

improving efficiencies, quality and service user/patient experience.

3.1.2. The Board provides leadership, strategic oversight and direction for all jointly commissioning and integrated activity. It is not directly responsible for key decision making, other than within the delegated authority levels of individual members, which remains with each organisation's respective governance processes as embedded in their separate constitutions. However the ICB operates at a senior level taking responsibility for developing joint proposals that impact upon health and social care in the Borough and, once agreed by their respective organisations, ensuring these are implemented and delivered thoroughly jointly managed arrangements.

3.2. **The ICB has been established to**:

- Support the work of the Health and Wellbeing Board in their key priorities
- Provide oversight and direction, making sure that key decisions are carried out once approved by the governance of each organisation
- Work towards a single approach to delivering health and social care across the Borough, and holding the system to account.
- Ensure that commissioning of services is always supported by strong and appropriate evidence of need.
- Review and monitor each organisations critical pressures, with the ambition of ensuring services are targeted to support those areas most at risk.
- Once agreed by each organisation's Executive, take the lead on the commissioning and delivery of integrated programmes for health and social care which meet national and local need.
- Oversee joint strategic development of service objectives, planning and financial monitoring of integrated services.
- Develop a co-ordinated approach to managing and developing the market across health and care services.
- Support the co-ordination and development of Joint Strategies, wherever possible, and wherever there is a shared user of services, including the JSNA and Health and Wellbeing Strategy.
- Have oversight and monitor the impact of all joint funded arrangements via a Section 75.
- Be responsible for co-producing the Local Plan, which allows both organisations to draw down the Better Care Funding (BCF).

3.3. **The ICB has an ambitious work plan, structured across the following four themes**:

3.3.1. Strategic enablers, including the development of integrated strategies for older people and mental health

3.3.2. Services for Children & Young People, including the review and coproduction of future services for emotional wellbeing and mental health

3.3.3. Further developing integrated care services for adults

3.3.4. Promoting personalised care for local people including developing new areas of work for the joint market development of the care homes market

3.4. **Integrated commissioning**

3.4.1. There are a range of existing shared or joint commissioning posts:

- Joint children's commissioning post
- Joint commissioning officer
- Care Homes Programme coordinator
- Associate Director of Discharge Commissioning & Urgent Care

3.4.2. Jointly commissioned services include:

3.4.2.1. **Bromley Well** – an innovative partnership of prevention and early intervention services managed by a voluntary sector consortium; funded via the Better Care Fund

3.4.2.2. **Dementia Hub** – commissioned to establish a clear pathway for people with dementia and their carers following diagnosis, providing a wraparound service for people who are diagnosed with dementia, their families and their friends. The service supports people in the early stages to ensure that support planning is in place, allowing people to remain independent for as long as possible and delay or prevent the need for social care or health crisis as far as possible. The service went live in October 2016, provided by a partnership of organisations: Bromley and Lewisham Mind, Age UK Bromley and Greenwich, Oxleas NHS Foundation Trust and Carers Bromley; funded by the Better Care Fund.

3.5. **Transfer of Care Bureau (ToCB)**

3.5.1. The ToCB was established in 2015 as part of a co-produced response to the one of the strongest challenges facing the health and social care system – the increasing number of patients with complex health and social care needs requiring support to be discharged from hospital in a safe and timely way. Successes since this time have included:

3.5.1.1. Delayed Transfer of Care (DTOC) have reduced significantly and patients are being transferred in a more timely way

3.5.1.2. The ToCB, with single oversight of all complex discharges, provided a fresh insight into systemic challenges and issues in the transfer of patient care and identified growing areas of unmet demand across the system. As a result several out of hospital pathways have been streamlined and a major procurement of community health services has delivered a robust community infrastructure, responsive to the changing needs in secondary care. The new community contract brings together rehab (home, bed and neuro) alongside hospital in-reach and rapid response services accessed through a single point of access in the community.

3.5.1.3. Rapid access to packages of care within 12 hours by care managers (and earlier when necessary), equipment delivered within 4 hours with major adaptations within 24 hours is now available with ring fenced step down accommodation available via

the ToCB to support more timely discharge from hospital.

3.5.1.4. End of life pathways have been strengthened through proactive in-reach to identify and pull patients out of hospital and provide responsive, home based care and support for those in the last 12 months of life.

3.6. Integrated Care Networks

3.6.1. Three integrated care networks have been developed with local partners, clinicians and patients with staff from a range of services and organisations working together in multidisciplinary teams.

3.6.2. Each ICN covers one-third of the population and brings together services delivering proactive care for patients with complex care needs. The aim is to keep these patients well and avoid a crisis, which may lead to them having to go into hospital. This new method of working is changing the way these patients receive care and how it is arranged for them.

3.6.3. The Proactive Pathway was mobilised at the end of October 2016 and weekly integrated Multidisciplinary Team meetings (MDTs) take place across all three networks. Service users and patients are proactively identified by their GP and assessed by a community matron before a discussion with a multidisciplinary team of staff working within the ICN including health and social care staff. This team works very closely together to support those patients and help keep them well.

3.6.4. New ‘Care Navigator’ roles have also been created to support patients and signpost them to the services they need, including voluntary sector services where suitable.

3.6.5. During 2017/18, the ICN’s have supported over 1000 patients through the pathway with a number of patients benefiting from onward referrals on to Bromley Well.

3.7. Care Homes Board

A joint Programme Board has been established to develop an integrated approach to the local care home market. Three work streams are in progress:

3.7.1. Work Stream 1 – Strategy

3.7.1.1. Develop a joint commissioning strategy for services from care homes based on a clear assessment of future needs, capacity requirements and identification of barriers to change and innovation

3.7.1.2. Joint review of market capacity and development of joint market management arrangements.

3.7.1.3. Integrated approach to Market Position Statements for frail elderly care

3.7.2. Work Stream 2 – Health and Social Care Offer

3.7.2.1. Determine the model health and social care offer to care homes in the borough, built around 3 local networks of multidisciplinary support, advice and care - to include primary medical services and medicines management.

3.7.2.2. Work with care homes to enable people to receive managed care in their home environment, to include end of life care, reducing the number of inappropriate emergency admissions to hospital.

3.7.3. Work Stream 3 – Quality

3.7.3.1. Develop and implement a joint approach to quality and safety within care homes to enable a consistent standard of service provision. to include workforce development, training and support programmes, robust safeguarding practices, and quality measurement and improvement