Report No.
CSD19178

London Borough of Bromley

Decision Maker:	**HEALTH AND WELLBEING BOARD**
Date:	**21st November 2019**
Title:	**One Bromley Update**
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Ward:	N/A

1. Summary

One Bromley will enable partners and services in Bromley to work as a single system to deliver integrated care. The strategic aims of One Bromley are to improve the health and wellbeing of the Bromley population. Providers and commissioners (CCG & LBB) from sovereign boards committed to working together to develop a single Local Care Partnership (LCP) delivering on joint priories. One Bromley will bring together partners as a single system coordinating care for the most at-risk and vulnerable individuals.

2. Reason for Report going to Health and Wellbeing Board

This report is to provide an update on the development of One Bromley focusing on:

- The context and development of One Bromley
- Opportunities of an integrated approach across health & social care
- Current status of the Bromley placed based Local Care Partnership (LCP) system
- Outline of key programmes, initiatives and enabler workstreams including progress and next steps

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

To note

Health & Wellbeing Strategy

1. Related priority: [Delete as appropriate] Diabetes Hypertension Obesity Anxiety and Depression Children with Complex Needs and Disabilities Children with Mental and Emotional Health Problems Children Referred to Children's Social Care Dementia Supporting Carers

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Financial

1. Cost of proposal: Not Applicable:

2. Ongoing costs: Not Applicable:

3. Total savings: Not Applicable:

4. Budget host organisation: N/A

5. Source of funding: N/A

6. Beneficiary/beneficiaries of any savings: N/A

Supporting Public Health Outcome Indicator(s)

Yes

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4. COMMENTARY

4.1 BACKGROUND

One Bromley System Development Summary:

4.2. Long Term Plan & Integrated Care System Approach

Integrated Care is central to the delivery of the NHS Long Term Plan (LTP) published in 2019. The LTP sets out different levels of commissioning and providing. These ambitions include:

- Local health commissioners and providers working much more closely with local authorities to aid the commissioning and delivery of integrated and personalised care
- Local Care Partnerships (LCPs) are established between local providers and commissioners to work for local populations
- Integrated Care Systems (ICS) are developed that are contiguous with single CCGs
- General practices working together in Primary Care Networks (PCNs) to ensure a population based approach to providing primary and community care, and other services

Work is also being taken forward to implement changes to commissioning across South East London, increasing collaboration across the CCG within the South East London STP and this in turn is supporting the development of a place based commissioning model at local level.

4.3 Background to One Bromley as a Local Care Partnership (LCP)

One Bromley LCP is comprised of the signatories to the Bromley Alliance, which was signed in October 2017. One Bromley is a partnership of commissioners, all major local NHS and non-NHS providers and the Third Sector Enterprise which aims to work together as a single system to:

- Enhance and improve the range, quality and effectiveness of services available to local people
- Enable partners and services in Brolmey to work as a single system to deliver integrated care

One Bromley will strengthen this approach by continuing to bring together providers, voluntary services and commissioners to build on the existing good work and deliver even more personalised and integrated care. This plan is to build on successes such as the Integrated Care Networks and replicated this across many other programmes of care. Patients need support from health and care professionals that act as one team and work for organisations that behave as one system.

4.4 Achievements to Date

One Bromley continues to support the transformation of health and social care in Bromley. Local organisations need to increase their focus on population health and work collectively to improve health and wellbeing. Bromley is already seeing substantial improvements for patients and for organisations in working together in this way, in outcomes and quality:

- 26% reduction in urgent hospital admissions & 22% reduction in unelective inpatient admissions for those patients who are 13 weeks post their MDT on the proactive care pathway (2,966 patients). This represents an estimated Emergency Department cost save of £81k (443 fewer contacts) and Unelective Inpatient Admission cost save of £267k (259 fewer contacts) across the same period.
- Pathway changes such as the virtual respiratory pathway, community heart failure, end of life and diabetes
- 8 Primary Care Networks including all practices in Bromley have been established as the basis of a population based approach. Currently 24 practices in Bromley are providing online consultations with a further 10 practices pending.

- @home service has been piloted to create a more integrated, community based system that prevents the need for hospital attendance and admission Pilot was successful in increasing number of patients supported by community healthcare services after discharge from hospital. The learning from the pilot is being taken forward through the streamlining of community pathways out of hospital to provide a single point of access for patients leaving hospital who require health and care support.
- A review of the Transfer of Care Bureau, located in the hospital, has been completed and there is a programme of work currently in place to improve the efficiency of the service it delivers to those patients requiring a supported discharge.
- Bromley has continued the improved DToC position of 2018/2019 into the first two quarters of 2019/2020 remaining below the set trajectory.
- A joint approach to improving the health and wellbeing of patients in care and nursing homes through the establishment of a special general practice exclusively for this population. To date, 31 Care homes have mobilised to the Bromleag Care Homes practice contract.
- The new Orpington Health & Wellbeing centre opened in September 2019. This is a significant achievement where the new centre includes services from various providers including GPs, Community services & others. Work is about to start on the new MRI suite.
- The Wave 4 funded increased Utilisation of Beckenham Beacon project is also well under way and due to complete at the end of November with Oxleas moving in and joint working across seven organisations in Bromley.
- Mental Health Wellbeing trailblazer in schools has commenced with 2 hubs (teams) working in schools to support C&YP with mental health challenges
- Investment in CAMHS via the mental Health Investment Standard has increased staff skill mix and capacity

4.5 One Bromley Workplan

One Bromley schemes will be delivered via a phased approach. Phase 1 will focus on UEC and management of winter pressures.

Key schemes in phase 1:
- Proactive Care
- U&EC including @home service
- Frailty pathway
- End of Life care
- Care homes

Key schemes in phase 2:
- Outpatient Transformation
- Primary Care Networks
- Diabetes
- Mental Health
- Children and Young People

Enablers
- Workforce and Organisational Development
- Communications and Engagement
- Finance
- Estates
- Business Intelligence and Population Health Management
- Contracting and Organisational Structure
- Digital and IT

These workstreams do not represent the full scale of the work of the partnership but have been selected as areas where various principles of integrated care could be applied.

4.6 Next Steps/ Progress

At a high level, work is being taken forward on the development of a LCP model in Bromley which will be aligned to the South East London STP and Bromley placed based commissioning. The following provides an overview and update on progress of some One Bromley schemes spanning health and social care:

4.6.1 Frailty

Commissioners (CCG & LBB) and Bromley Alliance providers are supporting the delivery of a number of initiatives as part of the One Bromley Task & Finish Group including:

a) Front door frailty identification/ MDT and assessment

A pilot initiative at the front door of Emergency Department (ED) is currently underway to focus on identification and effective management of frailty patients to reduce unnecessary hospital admissions. This will involve:

- Front door MDT approach to identify and initiate a Clinical Geriatric Assessment for patients with moderate frailty presenting at ED or admitted overnight.
- Identifying the most appropriate discharge pathway for patients not requiring medical interventions and admission across health & social care

The pilot was reviewed at a workshop event in September 2019 (what worked well, what can be improved upon and opportunities). The outline business case has been approved by King's and the next steps will be the development of a staffing model.

The new Frailty consultant is piloting a new approach to frailty scoring in Medical Unit 7 at the PRUH. This is to provide the better patient centred care in the right setting including community provision. Initial results have been promising with a reduction in hospital length of stay from approximately 30 days to less than 6 day. Plans are underway to mirror this approach on AMU.

b) Ambulatory frailty

Establishing a community frailty ambulatory service at Orpington Hospital for winter 2019/20 to enable the effective management of eligible patient:

- Step up provision to support the management of frailty across health & social care
- Step across from PRUH including ED
- Close working with Bromley@ Home service for continuity of care

The pilot will be launched during different phases- Phase 1 will commence in November 2019.

4.6.2 Proactive Care

The Joint Operational Group continue to implement changes and refinements to the Proactive care pathway to increase referrals into the pathway from outside primary care and streamline the referral process.

A workshop event will be held in December to review the implementation and improve:

- Approach in identifying the right patients and electronic frailty index
- Utilising effective incentives to drive change
- Alignment with other schemes such as frailty and 'super utilisers'
- Development of a case management approach considering the role of:
  - Primary Care Networks
  - Community Matron/ Nursing
  - Social prescribing and the wider role of the third sector

4.6.3 Urgent & Emergency Care

a) Winter planning

Joint with LBB/ CCG/ KCH plans have been approved identifying a number of schemes utilising winter resilience funding to manage pressures during the period. This includes increasing capacity across the system such as more primary care appointments, additional nurse and therapy support in the community, additional capacity in social care and the use of technology to support the monitoring of patients and residents.

b) Transfer of Care Bureau (ToCB)

A ToCB review workshop was held on 13th September 2019 to align staffing and structures with the needs of the service users. KPI's for the service are also being explored.

c) Community pathways

Externally there is an ongoing review of the pathways out of the hospital and the processes required. The focus is streamlining referrals into a single point of access to our community partners as well as strengthening the support from third sector workers to pull from hospital. For LBB/ CCG this includes the Rehabilitation and Reablement pathway and D2A workstreams.

d) Front door avoidance

Front door avoidance with emergency intervention teams working in ED alongside the frailty team. The high intensity user case manager role has been developed to case manage these patients. Quick access to community services is being provided to support patients in their own homes; this includes additional care manager support in ED. The post is being recruited to currently for appointment this winter.

4.6.4 Flu Campaign

One Bromley organisations are working together to support delivery of the winter plan. This includes encouraging take up of the flu/ shingles/ pneuvaccine both for residents at risk and staff working across the One Bromley LCP.

4.6.5 Mental Health

The CCG and LBB are working on delivering a joint Mental Health & Wellbeing strategy focusing on:

- Prevention & early intervention
- Multi- Disciplinary approach to treatment
- Complex and long-term support/ Recovery & Rehabilitation

A joint mental health pilot has been agreed and a basic model put in place to run a pilot in the Cray's plus another PCN. The pilot would provide dedicated mental health support in the community providing both medical (a consultant and a nurse) and social support via a Care Navigator (I.e. links with MIND and recovery works etc.).

Other initiatives being taken forward include:

- Shared care
- Extending mental health group programmes based in the community (lifetime membership approach)

4.6.6 Children & Young People (C&YP)

The C&YP programme is structured around 5 main areas:

- Healthy Start
- Co-ordinated Care
- Acute & Urgent Care
- Child & Adolescent Mental Health Services (CAMHS)

- Children with complex care needs (working closely with LBB)

To note the following areas of progress:

- The design of a potential 'at Home' service model is progressing along with the associated business case for evaluation.
- NHSE/I reviewed the Bromley CAMHS system on 30/31 October 2019. The outcome of this work is the development of an action plan to take forward the integration of the Oxleas CAMHS-Bromley Y Wellbeing service model.

4.6.7 One Bromley Communication & Engagement

The One Bromley Communications and Engagement group (a sub-group of the Bromley Communications and Engagement Network) has been established to support successful delivery of the One Bromley programmes and priorities. All One Bromley partners are represented and the group meets monthly. To date the group has developed the following:

- A comprehensive C&E strategy for One Bromley
- Branding for One Bromley
- Internal and external newsletters
- Website presence and content
- Engagement programmes to support One Bromley priorities such as Outpatient Transformation, frailty services and primary care networks.
- Integrated staff flu campaign to encourage take up and share good practice.
- Delivered a patient conference to gather views on One Bromley programmes.

4.6.8 Business Intelligence & Population Health Management

A new programme of work is being established that will develop into several potential enabler workstreams, broadly covering the following topics:

- Data Sharing
- Warehousing
- Business Intelligence
- Population Health
- Analytics
- Performance

Several pieces of work are underway to drive this programme forward. Planning has commenced to develop a Digital, Information and PHM and BI Working Group, which will serve to inform and address the programmes overall topics. Representatives of One Bromley are engaged in the new Population Health Development Programme in South East London being run by NHS England, which has the potential to provide opportunities for development and support for local Population Health Analytics initiatives. We are also developing the outcomes and monitoring processes for the Performance & Outcomes group. See 4.7 below.

4.6.9 Co-Ordinate My Care (CMC)

Coordinate My Care (CMC) is an NHS clinical service that was launched in August 2010 to deliver integrated, coordinated and high quality medical care, built around each patient's personal wishes. CMC houses an urgent care plan which is created jointly by the patient and their healthcare professional. It lists the patient's wishes and care preferences, including practical and logistical information.

A workshop has been set up for the 5th December, with key stakeholders to increase CMC usage. Despite some clear benefits to using CMC and the drive across London that it should be the care planning system of choice, there are several difficult blockages to work through that are hindering and in some cases stopping the uptake of increased utilisation. The aim of this workshop is to Increase the utilisation of CMC as the system of choice for care plans for frail, end of life and long term condition patients across One Bromley provider organisations. This will be achieved by working through and proposing solutions to the main blockages. These suggestions will then form workstreams to be delivered by a Task and Finish group to be set up post workshop.

4.7 Performance & Monitoring

The One Bromley, Performance & Outcome Group has recently been established to support the operational, performance management and economic and qualitative evaluation of a number of schemes that form part of One Bromley. The aim is to manage the performance and delivery of agreed outcomes for identified One Bromley Programmes and projects. Performance & outcomes will be measured at three levels:

1. One Bromley Strategic objectives (e.g. Improve health and wellbeing outcomes and reduce health inequalities across Bromley)
2. KPIs (e.g. Reduction in emergency admissions)
3. Local process measures (e.g. Patients seen through the pro-active pathway. Number of referrals. Waiting time etc.)

5. IMPACT ON VULNERABLE PEOPLE AND CHILDREN

N/A

6. FINANCIAL IMPLICATIONS

N/A

7. LEGAL IMPLICATIONS

N/A

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

N/A

9. COMMENT FROM THE DIRECTOR OF AUTHOR ORGANISATION

The One Bromley local care partnership continues to develop with an ambitious and wide ranging programme of work which brings improvements and benefits to patients and residents within the Borough of Bromley.