ENCLOSURE: 4

AGENDA ITEM: 6

# One Bromley Local Care Partnership Board

## DATE: July 2022

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| **Title** | **Partnership Report** | |
| This paper is for **information.** | | |
| Executive Summary | The purpose of this report is to provide the Committee with an overview of key work, improvements and developments undertaken by partners within the One Bromley collaborative. | |
| Recommended action for the Committee | The Committee is asked to note the update. | |
| Potential Conflicts of Interest | | |
| | | |
| Impacts of this proposal | Key risks & mitigations | Not Applicable |
| | Equality impact | Not Applicable |
| | Financial impact | Not Applicable |
| | | |
| Wider support for this proposal | Public Engagement | Not Applicable |
| | Other Committee Discussion/ Internal Engagement | Not Applicable |
| Author: | Joint report from SEL ICB, the PRUH, Oxleas, St Christophers Hospice, Bromley Council Adult Social Care, Bromley Third Sector Enterprise (BTSE), Bromley Healthcare, Bromley GP Alliance (BGPA), Bromley Primary Care Networks | |
| Clinical lead: | Not Applicable | |
| Executive sponsor: | Dr Angela Bhan, Place Executive Lead | |

# Partnership Report

## Integrated Care Board (ICB) and One Bromley Local Care Partnership update

Changes to CCGs come into effect on 1st July 2022. The first SEL Integrated Care Board meeting, will be held in public in central London. CCG staff (including the Bromley team) have been moved over to be employed by the newly established SEL ICB. Work on transforming and improving the health care system is ongoing, including preparing for next winter. This includes managing recent pressures for our vaccination services, for example, preparing for the autumn flu and covid vaccination campaign and undertaking a polio catch up programme.

## Princess Royal University Hospital NHS Trust

Our main focus continues to be the delivery of elective acute care, particularly to reduce the number of patients waiting an unacceptably long period of time for their treatment, built up since the COVID-19 pandemic. Whilst delivery needs continual focus, we identified and eliminated all patients waiting more than 104 weeks by 31 March 2022.

Whilst Covid is much less prevalent amongst the general population, we are still managing patients with Covid. As at 28 June 2022, the PRUH had 63 patients in general and acute beds, and 4 patients in critical care.

Our excellent performance towards better access to healthcare continues. Our diagnostic wait times have remained compliant since February 2022; meaning than less than 1% of patients are waiting more than six weeks for their diagnostic test. However, dealing with emergency pressures continues to be a challenge. Our performance improved from 67.86% for May to 75.89% for June to-date. This remains well below the four-hour target of 95%.

Our arrangements to oversee our capital developments continue to hold all parties to account for the delivery of a complex and extensive work programme across the remainder of this year and into next. The internal programme at the PRUH is delayed in places whilst we resolve contractual issues. Despite this challenge, we have made significant progress in delivering our longer-term objectives to improve the PRUH estate.

We secured successful planning applications for the link bridge and car park, both of which have started physically on-site. In Orpington we have established a fourth the state-of-the-art operating theatre and recovery suite since March 2022. Our Well-being hub for staff is in its final stages, with the handover occurring 28 June, and official opening in August.

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**Oxleas NHS Trust**

- Great Out of Hospital Care conference:

  More than 100 colleagues, partners, service users and members attended our Great Out of Hospital Care conference and exhibition in June. At the event, they learned more about how we are taking forward this key priority of the Oxleas Strategy 2021-24.

  Delegates heard from SE Integrated Care System Chair Richard Douglas who outlined the role of the new integrated system. “The Integrated Care System has three main objectives,” he said. “To improve health outcomes of local people, tackle inequalities and increase value for money and productivity. In my view, this Great Out of Hospital Care programme is central to delivering these.”

  The event included guest speakers and a showcase of some of the projects currently under way at Oxleas.

  The Great Out of Hospital Care programme is led by Oxleas Medical Director Abi Fadipe. A film of the conference can be viewed at: https://vimeo.com/oxleasnhs/goohc2022 and more details of Oxleas strategy and the priority workstreams is at: www.oxleas.nhs.uk/about-us/our-strategy/

- Oxcare patient online health record:

  We have been taking forward the roll-out of Oxcare our patient online health record since the programme’s launch in January this year. The system enables our patients to take control of their own health records, connects them with their care team and gives them the opportunity to add their own information about their health. The development team included local people who use a range of our services.

  Over the past few months, more patients and clinicians have taken up the opportunity to use the system. More information is available at: www.oxleas.mhs.uk/oxcare

- Crisis Line developments

  We have developed our mental health crisis call centre to improve services to local residents. The new service has been co-produced with people who have used services and is open 24 hours a day, seven days a week. Specialist trained advisors are able to assess over the phone the level of support required and action that support. It aims to help callers avoid the need to attend hospital emergency departments.

- Recognition Awards

  Nominations are open for the Oxleas Recognition Awards 2022. To nominate a team or an individual staff member, visit **https://www.smartsurvey.co.uk/s/StaffRecognitionAwards2022/**

  Closing date for entries is 10am on Monday, 25 July 2022.

**St Christophers Hospice**

As we emerge from the Covid pandemic we are actively considering how to ensure we are able to meet the needs of populations that we have, to date, not reached well.

- People with dementia; the team have been working to develop a Dementia Strategy following the hugely successful Conference of Dementia last financial year. This is a priority this year as dementia is now the leading cause of death in the UK. The publication of this strategy will also build on our plans to develop our offer into Care Homes and for those living with frailty by taking a rehabilitative approach that is key to attending to wellbeing and functionality for people living with dementia. As part of this work there are opportunities that exist to work in partnership with other organisations who have different/more expertise than the hospice. This might support efforts about addressing stigma, supporting early referrals and facilitating upstream interventions.
- As part of our accelerating work to address the need to refurbish our ward environment with the initial support of CRASH, a charity that supports homelessness charities and hospices with construction projects to create places that care for people, creates new opportunities to attend to the physical environment for people living with dementia in addition to improving our hospitality offer. This has seen the development of new principles related to hospitality and customer service
- The strategy also places a spotlight on the need to support research and education around approaches in caring for those living with dementia
- Marginalised groups;
    - In order to extend our reach to people who do not access our services we have recently engaged with the Croydon Faith Groups about our services in particular Choose Home. We are hopeful that this engagement with these groups will continue and develop over time.
    - Spiritual Care Review – Following the external review into the incident in Spiritual Care in the spring the Care Director has commissioned an external review of our Spiritual care offer to ensure that St Christopher's provides contemporary spiritual care to both staff, patients and carers. This review is expected to be completed by the end of August 2022.

**Improving the quality of services for people whose experience of end of life can be poor**

- Individualised care; The Care Directorate is cognisant of the need to ensure we deliver services that have a focus on particular characteristics such as age attuned or for those living with a learning disability. As part of this work we have been trying to recruit a Clinical Nurse Specialist with an interest in learning disability who can also support our younger client base. This post has been difficult to recruit to and is currently out to advert for the third time. We have sought advice from colleagues working at Croydon Hospital who specialist in learning disability to not only provide education and support to our team but also to advise on particular components of the Job Description.

- Support to people living in Care Homes; 2021-2022 saw the need to return people, who had lived, confined, through the first wave of covid in a Care Home to their baseline level of fitness and wellbeing. An innovative pilot in Bromley Care Homes utilising our Rehabilitation and Wellbeing Teams was successful and the outcomes shared across our CCG Commissioners. This project won an award at the One Bromley Award Ceremony in May 2022 for its work. This is in addition to the Winter Pressures work in Bromley that produced excellent outcomes for residents in Care Homes including;
    - Improved support to staff and families around palliative and end of life care including Advance Care Planning discussions and Treatment Escalation Plans
    - Embedding a subcutaneous fluid offer
    - Improving access to medicines
    - Starting to work up a care Home based IV antibiotic pathway across providers
    - Working closely with the newly developed frailty unit
    - Encouraging hospital admission from Care Homes

In addition to having a dedicated nurse for Care Homes in our Single Point of Contact we are working closely with Commissioners to understand how we can improve our offer to Care Homes across Quarters 2-4 this financial year

- Support to those living with complex mental health issues; post covid this element of our care provision remains more vital than ever. We are planning on looking at our provision of mental health services and enhancing the offer already provided by our Consultant Psychiatrist. This will remain a work in progress over the year. Support from this psychiatrist has been vital through case reviews in some of the extremely complex decision making required in the first quarter of this year.
- We are holding a Rehabilitation Conference at the beginning of July with 100 attendees many of who are external delegates. This has allowed us to share our expertise nationally around the importance of rehabilitative palliative care

**Increasing throughput of patients in receipt of clinical support from the hospice**

The two years of Covid saw our clinical caseloads increase by 25%. Proactive management of caseloads across our community teams continues to reap its rewards with the caseloads now slightly below that pre covid. We have implemented measures to support active caseload management including;

- Discharging the people under our care after a spell with us and encouraging patient initiated follow up (PIFU). This means that any patient or carer who is discharged can call into the organisation and reconnect with the clinical team at any time should they need to do so.
- We are encouraging early referral to the hospice by our stakeholders. Monthly communications continue to stakeholders reinforce the importance of early referral to improve patient outcomes
- We are looking at ways that we can encourage self-referral for care. Our early thoughts are around promoting our rehabilitation and wellbeing offer for self-care. Although this

remains a work in progress it is important to note that we would never refuse to take on a patient who had self-referred.

- Choose Home continues to grow in its offer and we have started supporting people discharged to a Care Home from the Inpatient Unit a visit from a Choose home member of staff the day after discharge to support the Care Home Team care for the patient; advise on medications and generally from a bridge of care from one setting to another.

**Responding to needs responding post COVID**

As we emerge from Covid the Hospice is 'opening up again'. This is giving us an opportunity to look at what we want to stop, restart or develop. Investing effort into rehabilitation services to support those earlier in their trajectory must be a focus of time in addition to understanding what the people who use our services really want in addition to learning to work across the new Integrated Care System of South East London. St Christopher's is actively participating in both South East London and Pan London Palliative and End of life work to help shape and deliver contemporary hospice services into the future.

**Developing our inpatient offer**

A focus has started on improving our offer to people who stay with us on our inpatient unit both with respect to care services but also to a wraparound hospitality offer. There are five working groups looking at

- Hospitality
- Tools for holistic assessment
- Individualised (rehabilitative approached)
- Evidenced Based care
- Use of technology

This work is gaining momentum and dovetails nicely with the start of the ward refurbishment project in earnest.

## Bromley Council Adult Social Care

Despite dealing with Covid we have made significant changes and improvements in the last few years.

To name a few: We have developed and delivered award winning hospital discharge arrangements and an improved relationship with our care providers, working across all agencies. We have launched our strategy to deliver strengths-based outcomes and organised our teams so that they can work with PCN's in a real way.

We have delivered integrated arrangements across social care and health enabling us to deliver the tendering and letting of new contracts for home care, learning disability, and the Bromley Well service in order to meet the targets set in our agreed and published strategies for Ageing Well, Learning Disability, Mental Health and Loneliness.

## Bromley Third Sector Enterprise (BTSE)

Bromley Well delivers the Primary and Secondary Intervention Service commissioned jointly by London Borough of Bromley and NHS. We helped almost 10,000 clients in 2021-22.

BTSE has been awarded the PSIS contract starting in October and so will continue to deliver Bromley Well services from October until 2027. The new contract is broadly the same but some changes.

The Mental Health Pathway is transitioning to be delivered in partnership between BLG Mind and Oxleas. Bromley Well working closely with BLG Mind and seconded Triage post to ensure smooth transition and continued support for mental health issues through Bromley Well Single Point of Access (SPA)

High level of take up for Bromley Well handyperson service. This is significant in helping keep Bromley Residents in their homes with the installation of Key safes, handrails, alarms and a range of other services.

Wider Elderly Frail Services including Long Term Health Conditions continue to see high volumes with over 1000 residents supported by LTHC alone.

Bromley Well is working towards the Carer's Trust Excellence for Carers Award. There are 31,000 carers in Bromley. Last Year Bromley Well supported over 1800, Adult, Mutual, Mental Health and Young Carers. Carers support is a key element in helping avoid hospital admissions and supporting earlier discharge.

Bromley Well has significantly overperformed in helping the number of those with Learning or Physical disabilities into employment and education.

Bromley Well SPA continues to take a high volume of queries, well over 200 a week. Significant proportion of queries (over 30%) now relate to cost of Living issues and increased demand for Information and Guidance support across Bromley Well Services. This is only likely to increase in the coming months.

## Bromley Healthcare

New Community Standards: Urgent community response teams provide urgent care to people in their homes to avoid hospital admissions and enable people to live independently for longer. Bromley Healthcare (as part of SEL community providers) was one of the seven national accelerator sites as an early adopter of the two-hour standard. This is the first standard for community services which has been published nationally. For the first publication, the data is reported from the Community Services Dataset, with 80% (against a national target of 70%) of the 235 referrals made in April being seen by the team within two hours.

### Bromley Healthcare Care at Home

Bromley Healthcare acquired a domiciliary care agency (Linkcare) in August 2021. The agency provides around 900 hours per week across Orpington and Bexley. As a social enterprise our aspiration is operate the agency under a corporate social responsible model recompensing carers fairly, providing a development continuum for carers into nursing/ therapy roles (as part of our ‘grow our own strategy’) and joining up social and community healthcare around patients. From the 4th July the Care Agency is being rebranded to Bromley Healthcare Care At Home.

Career pathway

With national recruitment challenges in two of our core services, District Nursing and Health Visiting, new career pathways are being introduced as part of the 'Grow our own Team' strategy. The District Nursing Career Pathway is aimed at improving recruitment and retention, developing and supporting colleagues in order to maximise expertise. Clinical quality leads are in place supporting each of the four Neighbourhood Teams with professional accountability into the Head of Nursing. New caseload holder posts recognise the increasing complexity of patients and will enable full ownership and accountability of caseloads as well as providing development opportunities for colleagues who previously may have moved to specialist nursing roles. Progression opportunities for newly qualified nurses who have graduated from our readiness programme and successfully achieved competencies have also been incorporated. Similarly, in Health Visiting band 5 nurses have been recruited who will start the academic Community Health modules in September following an internal training programme in July 2022.

Wheelchair Service – change of location

The Bromley Wheelchair service has moved to newly refurbished premises at Ruxley from the Slade Green centre. The team have moved into the office base with the three clinic rooms due to be in operation from the 1st September. Members of Bromley Healthcare's Patient Reference Group, Matthew and Deirdre Brockhouse attended for a site visit suggesting a number of changes which are being implemented before the clinic opens.

**Bromley GP Alliance (BGPA)**

GP Access HUBs continue to support primary care and improve access for Bromley patients, with a balance between virtual and face to face appointments. BGPA is working with PCNs to agree on a way forward from October. Workforce challenges exist and recruitment and retention work is underway.

Bromley Care Practice is also trying to recruit to its full workforce capacity. There is a planned expansion in care home residents in Bromley, with more than 200 new places becoming available. Well over 90 percent of care home residents have received their Covid-

19 spring booster, with 100 patients remaining  who were not eligible, in hospital, unwell or have just moved in a care home – these will all be offered vaccination at the appropriate time.

BGPA continues to support the GP CAS111 system by receiving NHS111 referrals daily 8am-8pm into GP led clinics when general practice capacity is full.  Previously, these patients would have been diverted to UTC.  BGPA offers 66 appointments per day with any unused capacity being opened up to practices to refer into.  Patients who need to be seen on the day are booked into a face to face appointment.

The formal covid management services will cease after 30th June 2022. BGPA has introduced a remote platform (Doctaly) which allows patients with Covid to upload daily readings for clinical review. BGPA have reduced Hot HUB to 3 per week primarily to support any patient seen in the CAS or hub session who has symptoms.

COVID mobile vaccination clinics at the Orpington Health and Well Being Centre finish for the moment at the end of June.  Vaccines for the housebound are also due to completed at the end of June 2022.  Practice satellite housebounds (with BGPA suppling the vaccine) are due to finish by 9th July. Vaccination services will be 'paused'  from 15th July 2022.

BGPA provides phlebotomy across 10 sites across Bromley (one in each PCN area) and also supports the booking of patients for the PRUH services (at Beckenham & Orpington).  BGPA introduced an innovative online booking system in 2020 and is now seeing 66% of patients using this method.

The Health Inequalities Pilot in Penge has started and is running weekly providing health checks (GP and nurse led) to try and engage with hard to reach patients.  This will run throughout June and July and offers both walk-in and bookable appointments. This is available to patients registered within Penge PCN though any unregistered patients will be encouraged to register on the day.  Attendance has been; week 1, 5 clients, week 2, 7 clients, we have 9 booked for week 3

All other services are running at full pelt with excellent Family and Friends and clinician feedback.

**Bromley Primary Care Networks**

Bromley PCNs have led five of the twelve Covid vaccination centres across Bromley at the height of the vaccination programme. Three of these sites were led in conjunction with BGPA, which provided site management and clinical leadership. As the Spring booster programme comes towards an end, a number of these sites are now pausing, whilst PCNs have started planning for Covid and flu vaccination delivery this autumn and winter.

In line with the wider system, PCNs have had a focus on catch-up and recovery for routine and preventative care. This has included childhood immunisations, health checks for patients with Serious Mental Illness, and annual health checks for patients with Learning Disabilities. As part of the response to winter pressures, two PCNs operated pilots for same-day hub services, which sought to help manage demand on the urgent and emergency care system.

PCNs are now preparing for new targets in the Network Contract Direct Enhanced Service; these include provision relating to structured medication reviews, early cancer diagnosis, cardiovascular disease prevention & diagnosis and the new Enhanced Access service.

The Enhanced Access service requirements presents a significant change to the current model of PCN extended hours and access hub services. From October, PCNs will establish ‘Network Standard Hours’ of operation, providing weekday evening and Saturday services (6.30pm-8pm Mondays to Fridays, and 9am-5pm Saturdays). In readiness for this change, PCNs are engaging with patients, configuring PCN-wide clinical systems and planning their service models for Enhanced Access.

Utilising available data on health inequalities, each PCN has identified a population within the PCN experiencing inequality in health provision and/or outcomes. Working with organisations within the Local Care Partnership and with the selected population cohort, each PCN has developed and is implementing a plan for identifying and addressing the unmet needs of this population. This is a significant step towards integrated neighbourhood teams.

This year, PCN teams have expanded to include Mental Health Practitioners, jointly employed by PCNs and Oxleas, who are helping to improve the delivery of mental health services in primary care. PCNs will be further expanding the PCN workforce roles and are currently conducting their workforce planning for the coming 18 months.