Bromley Local Care Partnership (1/6)

South East London Integrated Care System

Vision

Help everyone in our population live longer, more independent lives with less variation in health outcomes across Bromley

Deliverables / Improvements since 2023/24

- Embedded children & young people and adults mental health single point of accesses: offering blended voluntary and NHS support services, delivered alongside reduced CAMHS waiting times
- Bromley Children's Integrated Health Partnership covering all Bromley: 90% of patients avoid hospital
- Re-imagined One Bromley Health & Wellbeing Hub opened: linking people with statutory and voluntary services
- Commenced delivery of refreshed frailty strategy across One Bromley focussed on identification, prevention and more co-ordinated working
- New joint needs assessments in mental health and learning disabilities, and for children & young people with co-production on developing new strategies
- Social worker in A&E supporting the Department as a front door to social care
- Went live with new community health contract 2024-26 and specified contract for 2026+
- Procured and prepared for launch new Mental Health and Wellbeing Hub – opening April 2025
- Launched Bromley Mental Health Support@Home: a new supported living service for people with long-term mental health conditions
- New therapies offer launched across Bromley for children and young people
- One Bromley Carers Charter: commitments and action to better identify and support unpaid carers
- Delivery of 3 priority areas of urgent and emergency care improvement leading to 50% increase in virtual ward capacity and reduced need for patients to revisit hospital ambulatory services. Hospital at Home Service won national award for its collaborative and innovative work
- Developed new care model for multiple long term condition management through INTs
- Expanded reablement offer with social worker alignment reducing care assessment timescales
- Agreed footprints for integrated neighbourhood teams within a wider tired approach to neighbourhood working and commenced moving existing neighbourhood work into new footprints

Key Challenges / Opportunities Remaining

Opportunities

- Using INTs to co-ordinate care around our residents proactively and reactively to reduce need for acute and social care
- Population health management tool across Bromley to more efficiently and effectively target proactive, prevention and personalised care
- Re-imagining payment and incentive structures to support multi-organisational working
- Strengthening adult safeguarding arrangements across agencies

Challenges

- Organisational development of emerging INTs: supporting staff to build formal structures and connection with locality
- Place-wide co-ordinated approach to accessing shared patient records to support integrated models of care.
- Organisational capacity and capability for change given available resources, including as result of collective management cost reductions and time demands on senior clinical leaders.
- Restricted capital funding for premises and IT.

Bromley Local Care Partnership (2/6)

	What are our priority areas for 2025/26	Why has this been identified as a priority areas?
1	Establish new joint working in integrated neighbourhood teams	• Bromley has largest volume of people with multiple long term conditions and those over 65 in SEL • There is an opportunity to better support people to avoid hospital or care home re/admission • Public engagement and research identifies opportunity to improve health equalities through proactive and co-ordinated management of care. INTs can be designed to deliver this new approach
2	Put in place population health management tool and approach to risk stratify and better target interventions	• Population health management tools enable more effective allocation of resources to population needs, supporting left shift and improved wellbeing • Utilisation of tools can support improved personalisation of care – in line with our strategic goals
3	Transform all age learning disability services and mental health and welling prevention and early intervention services	• JSNA for all ages mental health services and adults with a learning disability, plus co-production with residents, carers and those accessing services, identified growing need and new service priorities • Focus on health inequalities in mental health cohort (e.g. young mums) and for young adults with a learning disability transitioning from statutory children's services
4	Improve universal and targeted service to meet the needs of Children and Young People (CYP) at the earliest stage	• Bromley largest CYP population in SEL • Joint Strategic Needs Assessment identified areas where we can improve outcomes • Demonstrated success of B-CHIP and desire to build on this to drive increased system efficiencies and improved patient and family outcomes and impact

Bromley Local Care Partnership (3/6)

South East London Integrated Care System

Priority Area:	Priority Area:
Establish new joint working in integrated neighbourhood teams	Put in place population health management tool and approach to risk stratify and better target interventions

What are the actions we will deliver in 2025/26	What are the actions we will deliver in 2025/26
- Core INT development: In each INT footprint bring together multi-agency teams to build cohesion, develop deeper connections with local population and its mLTC and frailty needs, identify quick wins for closer working, and operationalise initial multiple long term condition management model for go-live cohort. Repeat for frailty and subsequent LTC management cohorts. - Enabler development: establish integrator function, secure and deploy workforce organisational development and training packages focussed on mLTC and frailty; cross system tool for frailty identification; review colocation.	- Agreed digital strategy across One Bromley partners articulating the role and requirements of a population health management tool. - Select agreed population health management tool for use across Bromley. - Agree appropriate expertise and approach required to maximise utility of PHM tool, including predictive risk stratification. - Agree data sharing arrangements across all Place partners. - Agree arrangements to strengthen oversight for adult safeguarding

Population Health and Inequalities Impact	Population Health and Inequalities Impact
- INTs focus on the needs of their local population and work with communities. - Improvement of management of multiple long term conditions for those in Core20 areas. - Frailty prevention and identification delivering improved health outcomes.	- Identification of individuals with high health and care needs, and those predicted to have those needs in the future: allowing targeted proactive and safeguarding interventions, including with our Core20PLUS5 populations.

System Sustainability Impact	System Sustainability Impact
- mLTC – ambition to better manage psychosocial, medical and mental health factors, mitigating need and costs in urgent acute and long term social care. - Frailty – earlier identification and management, mitigating costs in acute and social care, improved resident resilience, self and family management.	- Identification of individuals who may benefit from earlier intervention and proactive management, supporting reduced need for acute and long-term social care – initially support mLTC management and frailty work through INTs.

Bromley Local Care Partnership (4/6)

South East London Integrated Care System

Priority Area:	Priority Area:
Transform all age learning disability services and mental health and welling prevention and early intervention services	Improve universal and targeted service to meet the needs of Children and Young People (CYP) at the earliest stage
What are the actions we will deliver in 2025/26	**What are the actions we will deliver in 2025/26**
• CYP: 1) Embedding integrated single point of access between Bromley-Y and CAMHS; 2) Implement new step-down pathway between CAMHS and Bromley-Y; 3) Deliver new contract with Bromley-Y with focus on prevention activities; 4) Embedding interface work between children's and adults services to enable transitions. • Adults: 1) Enhancing MH single point of access with talking therapies and improved outreach to primary care; 2) recommissioning of talking therapies; 3) improved discharge processes with Oxleas and London Borough of Bromley Adult Social Care; 4) Improved outcomes following healthcheck for adults through support for individuals to make lifestyle change; 5) improved pathway for older adult mental health to reduced need for specialist nursing home care.	• B-CHIP: 1) Work with partners in early 2025 to scope expansion of this model to other areas of need and demand as INT; 2) Develop an approach which fits within B-CHIP / INT framework of delivery; 3) Pilot as agreed. • LTC: 1) Deep interrogation of CYP Joint Strategic Needs Assessment to establish areas where could have impact for CYP LTC, alongside root and branch review of LTC pathways; 2) work with partners to develop approaches and plans that deliver a preventative service for CYP and families; 3) pilot one initiative while refining the LTC pathways.
Population Health and Inequalities Impact	**Population Health and Inequalities Impact**
• All target group is Core20PLUS5. • CYP: Improved education outcomes; improved children social care outcomes; improved self reported wellbeing scores: improved readiness for adulthood and responsibilities. • Adults: Improved skills and employment outcomes; more people, living independently in their own home; improved self reported wellbeing scores.	• Targeted to areas identified where greatest improvement to CYP health and wellbeing could be made as identified through 2024/25 refreshed CYP Joint Strategic Needs assessment and mental health joint strategic needs assessments. • Through the above, delivery of improved outcomes for those in Core20 areas.
System Sustainability Impact	**System Sustainability Impact**
• CYP – improved prevention offer to reduce hospital admission and CAMHS activity, with a shift to third sector & support education outcomes. • Adult – reduce hospital length of stay, admissions and re-admissions; shift to voluntary sector with more people in employment and living independently in own home; commence impact on long term: reduced need for specialist care home support .	• Prevention focus to addressing long term conditions, supporting family resilience and reduced acuity of need. • Productivity and left-shift through B-CHIP with significant reduction in acute instances of care, making every contact count and increase in community based working. Building on experience of financial efficiencies derived through existing B-CHIP working.

Bromley Local Care Partnership (5/6)

South East London Integrated Care System

Priority Area	What are the outcomes we are aiming to achieve?	How are we measuring our impact?
Establish new joint working in integrated neighbourhood teams	• Earlier identification of people in poor health and associated risk factors driving earlier and co-ordinated care planning • Greater connection of residents with local third sector and community-based services to slow increases in need • Improved co-ordination of care and health arrangements around individuals, proactively and reactively	• mLTC - A&E attendances; rates not seen in primary care; social prescribing referrals • Frailty - % over 65 receiving clinical frailty scoring at healthcare interaction; % over 65 with CFS 5+ getting Comprehensive Geriatric Assessment, care admissions, safeguarding interventions • Overall staff connected-ness and resilience
Put in place population health management tool and approach to risk stratify and better target interventions	• Place alignment on population health management tools and approach • More effective allocation of resources to population need through delivery programmes	• PHM tool agreement in place • Sign up of Place partners to data sharing to improve population health outcomes and reduce inequalities • Tool in place and utilisation commences
Transform all age learning disability services and mental health and welling prevention and early intervention services	All age: • Reduction in need for secondary and specialist care • Improved education and employment outcomes • Improved self reported wellbeing Adults only: • More people living independently in own home • Young adults with a learning disability supported in their transition to adult services	CYP • Reduced hospital and residential care admissions • Reduced CAMHS caseload • Reduced referral to specialist services Adults • Reduced hospital and residential care admissions • Reduced referral to specialist services • Reduced need for specialist nursing home care
Improve universal and targeted service to meet the needs of Children and Young People (CYP) at the earliest stage	• Shift from acute hospital to community-based care • Improvement in multi-professional, multi-agency working • Improved patient and family experience of services • Making every health, social care and education contact count • Improved management of long-term conditions and reduction in exacerbations	B-CHIP • Reduced post intervention primary and secondary care attendances • Reduced waiting times and waiting lists • Overall system efficiencies • Patient and professional experience LTC • Reduction LTC exacerbation

Bromley Local Care Partnership (6/6)

South East London Integrated Care System

What do we need from enablers and partners to deliver?

- **Digital enablers for connected care**: Functionality for working at scale across primary care networks, integrated neighbourhood teams and wider system. Population health management tools and expertise shared across SEL for improved efficiency. Patient self management and escalation tools considering digital access.
- **Estates**: Levering investment into the Borough to support estates development. Delegation to Place for decision making and the primary care estates budget. Improve the quality of existing estate and ensuring robust contractual arrangements in place to provide stability for future use.
- **Workforce**: Staff sharing agreements for joined up services enabling safe and effective working across organisational boundaries. Joint training and wellbeing programmes to support INT working.
- **Finance**: Continued investment into services, including community diagnostic capacity. Shared financial reporting across health and social care providers in Bromley to understand the impact of change initiatives on the Bromley pound.

How will we work in collaboration with our system?

- **Programme approach:** Each programme is overseen and supported by One Bromley programme boards with representatives from across Bromley partners. All programme boards report into the One Bromley Executive.
- **Change model:** Using the NHS Change Model our large scale change programmes work with senior operational and clinical leads through system wide working to jointly define the 'why' of change and then utilise a quality improvement approach to implementation: involving teams in change and reflecting back progress and challenges for joint problem solves.
- **Engaging staff:** We will work with our staff across organisations to develop and establish new INT ways of working, supporting ownership and innovation.
- **Ensuring safeguarding:** We will work together to safeguard both children and adults – embedding the approach through our changes.

How will we engage with our population?

- **Focus:** Our engagement focus will remain on the elements of change where feedback from service users will make the biggest difference to how services are shaped and delivered, helping to support our ambitions to better support our Core20PLUS5 groups in Bromley.
- **INTs:** Our INT development work will work with local residents in each INT, supporting the development of pathways tailored to local needs and requirements.
- **Using existing mechanisms:** We will utilise our existing feedback mechanisms through One Bromley organisations, our community champions, and bespoke approaches to enable this work, reaching beyond our traditional networks.

How will we monitor and share progress?

- **Strategically aligned:** Our One Bromley Local Care Partnership Strategy from which this plan flows is owned by our Local Care Partnership Board. It has a joint delivery plan with the Health and Wellbeing Board, which is supported by a small programme management function and delivery overseen by the Bromley Executive and Health and Wellbeing Board. This cements a cross-system approach to change management and issue mitigation.
- **Monitoring and sharing:** One Bromley programme management office monitors key delivery & enabler programme progress and shares learning between programmes.
- **Evaluation:** As part of INT development in particular the system is utilising evaluations of existing services to inform design and exploring its approach to a Quality Management System with linked with Quality Improvement to establish psychologically safe, improvement focussed multi-agency teams.