South East London Integrated Care System

Bromley borough

NHS South East London

Our population

- **Population expected to rise** to 345,350 by 2027. **Second oldest population in London** (17.7%) - expected to grow to 67,400 over 65s by 2030. Life expectancy is 81.3 for men and 84.9 for women, with up to 8.4 years of variation between wards. **People live on average 17.7 years in poor health**. Net growth in child population is in the 11-18 age group.
- Index of multiple deprivation shows Bromley's **east and north west has wards in the most deprived 10% and 20% nationally**, equally Bromley's **central belt and far south west have wards in the least deprived 10% and 20% nationally**.
- The ethnic minority population of Bromley is 19.8% with Black African population the fastest growing BAME group. **19% of 0-4 year olds in Bromley are from BME groups compared to 5% of those post retirement age**. Between 2017 and 2027 the overall **ethnic minority population is projected to rise by 23%.**

Health outcomes for our population

- The main underlying causes of death in Bromley 2016-2020 were **cancer** (29.5% of deaths), **circulatory disease** (27.9%) and **respiratory disease** (13.9%).
- Other areas of opportunity to improve health outcomes for Bromley include:
  - **Obesity** 57% of adults overweight or obese, 340 children obese in year 6 with higher rates of child obesity in north east, north west and Mottingham areas
  - **Diabetes diagnosis rate** of 66.1% is poor compared to England and London, with over 15,000 people diagnosed with diabetes and 30,000 estimated at risk
  - **Dementia** 4,380 people aged 65+ live with it, estimated to rise 50% by 2030. Bromley has higher rates of young-onset dementia than England and London.
  - **Adult mental health** 10.8% of GP patients diagnosed with depression, 6th highest London borough, and higher rates of chronic ill health than general population.
  - **Adolescent mental health** 1,702 pupils with social, emotional and mental health needs, while drug use among young people higher in Bromley than London.

Inequalities within our borough

- **Deprivation** Life expectancy lower in more deprived wards, especially for men. More adults report poor health in Cray Valley & Mottingham and Chislehurst North.
- **CYP** Children in north east & north west and Mottingham have the highest rates of obesity. Teenage pregnancy rates highest in areas of greatest deprivation and where more children live in households with unemployment and financial issues.
- **Substance misuse** Low levels of recorded drug use mask high rates of opiate and/or crack use in 15-24 year olds. Hospital admissions and drug-related mortality highest in most deprived wards.
- **Sexual health** 50% of STIs in Bromley diagnosed in 15-25s; they, plus men who have sex with men, and Black African/Caribbean ethnic groups have the highest rates of new STI. Majority of new STIs in 2017 were diagnosed in the more deprived wards.
- **Learning disabilities** Shortfall in the number of people identified with learning disability who have had an annual health check.

What we've heard from the public

- Strong support for moving more care into the community, including: ease of access at the One Bromley Health Hub, positive response to plans to develop a Bromley Town health and wellbeing centre, Beckenham Urgent Treatment Centre felt essential service for that geographic area; exceptional user feedback for Children's and Adult Hospitals at Home.
- Frustration regarding accessing primary care in general and getting information on waiting times, including at our Urgent Treatment Centres.
- Mixed responses on use of technology for home monitoring: generally positive from those who have used it, but caution when considering establishing virtual wards.

Bromley - Our objectives and priority actions

Our key objectives - what we want to achieve over the next five years

Improve population physical and mental health and wellbeing through prevention & personalised care

- Evidence driven population health improvement by tackling inequalities, improving outcomes and services formed around the needs of service users.
- Patients and carers supported in the management of long term conditions – including transitions between services.
- Meeting the needs of Bromley's elderly population as well as children and young people.
- Influencing the strategy of partners on wider determinants of health.

High quality care closer to home delivered through our neighbourhoods

- Primary care is on a sustainable footing and tacking unwarranted variation in patient outcomes, experience and access.
- Neighbourhood teams based on geographic foot-prints provide seamless services across health, social care and third sector services.
- Improved access by moving services from hospitals and into the community & people's home and delivering new approaches for mental health care and services for children and young people.
- Monitored and maximised the health and care resources for our population.

Good access to urgent and unscheduled care and support to meet people's needs

- Residents have and understand how to use same day and emergency care across Bromley spanning physical and mental health, social and third sector care.
- Services meet the needs of the population and support people into non-urgent care once their urgent needs are met.

Our priority actions

1. Deliver evidence-driven population analysis to support teams in targeting prevention and improving population health outcomes
2. Evolve neighbourhood teams into integrated geographic footprints to meet health and prevention needs of the local population: spanning primary, community and social care, with third sector and specialist physical and mental health
3. Implement our care closer to home programmes across Children's and Young People, Community Mental Health Transformation, and Hospital at Home
4. Establish and deliver development plan to support primary care sustainability
5. Coherent system-wide approach to integrated urgent care in a more sustainable model and easier to navigate for professionals and all service users

Supported by a One Bromley culture and wider enablers:

- One culture to help us deliver joined up services
- Asset-based community approach with an engaged population
- One Bromley organisations are tied to the wellbeing of the populations we serve
- Maintaining and securing resources for the needs of children and adults in Bromley
- Workforce, estate, digital tools (including analysis and artificial intelligence) and finance in place to deliver our priorities

Bromley – Our progress to date

Key Successes in Delivery in 2023/2024

- **Launched children & young people and adults mental health single point of accesses**: offering blended voluntary and NHS support services, delivered alongside **reduced CAMHS waiting times**.
- **Initiation and expansion of Bromley Children's Integrated Health Partnership**: 90% of patients avoided referral to hospital – instead, seen closer to home and at least 20 weeks faster.
- **Embedding of health inequalities-funded neighbourhood working**: connecting people with others in similar situations, statutory and voluntary services; alongside trial of **'one stop shop' model in a wellbeing hub**.
- **Hospital at Home services expanded:** providing an additional ward of acute capacity to the Bromley system - delivering holistic, patient-centred care with exceptionally positive patient feedback.
- **Mobilised new urgent treatment centre contract** across two sites in Bromley with key targets now being met.
- Piloted **multi-disciplinary, multi-organisational** review of care and nursing home residents most at risk of admission to hospital and updated patient universal care plans used by London Ambulance Service and others.
- Further embedded use of **Consultant Connect to improve interface between primary and secondary care**: highest call rates of all South East London boroughs.
- Invested in **community champions** to enable more resilient champions able to more confidently share information about our health and care services in communities.
- **Introduced remote monitoring in primary care**, empowering patients in managing long term conditions and using clinician time more efficiently.
- Begun **implementation of modern general practice** models to help manage demand and improve access.

Key Challenges to Delivery in 2023/2024

- Securing **linked patient identifiable data-sets** system to enable proactive prevention and personalised care actions included in this delivery plan.
- Access to **shared patient records** remains a challenge placing pressure on integrated models of care.
- Identifying how to **make best use of community assets** to as part of neighbourhood working: supporting design, implementation and self-sustaining work.
- Challenges resulting from implementation of **new secondary care patient record system**.
- **Organisational capacity and capability for change** given available resources in 2023/24 and onwards, including management cost reductions and time demands on senior clinical leaders.
- **Restricted levels of capital funding** for premises and IT equipment

Learning and Implications for Future Delivery Plans

- Governance in place for 2024/25 to support **neighbourhood development**, dovetailing community and national priorities, providing strategic oversight, challenge and support, including through a suite of tools for successful change delivery provided by and shared between system partners. To include a shared approach to evaluating work.
- **Integrated Urgent and Emergency Care** model will dovetail with 111 procurement, with implications for local and joined up urgent care services for patients.
- Further collaborative development of **sustainable Primary Care model** through 2024/25.
- Doing **more 'once' for One Bromley** – recognising availability of expertise and resources for business as usual and change.

South East London Integrated Care System

Bromley priority action 1 – evidence driven prevention and population health

NHS South East London

Deliver evidence-driven population analysis to support teams in targeting prevention and improving population health outcomes

Establish the evidence and analysis requirements, means of delivery and support to planning and operational teams for evidence driven population health analysis. This will enable population segmentation into actionable groups at place and neighbourhood level, with an initial focus on our areas of greatest population health opportunity: living with long term conditions, frailty, experiencing health inequalities (Core 20Plus5) and those at risk of emergency admission. Alongside Programme 2, focussed on developing neighbourhoods, this will enable us to work with identified groups, understand the drivers of inequalities and co-design solutions for healthier lives, including the wider determinants of health.

How we will secure delivery

Actions for 24/25

- Population health analysis and local intelligence held by health, care, third sector and SAFER Bromley partners identify those living with long term conditions, frailty, experiencing health inequalities (Core 20Plus5) and at risk of emergency admission.
- Utilise care closer to home initiatives (Programme 3) to identify and support those we could help the most – e.g. Children's hubs; mental health single points of access.
- Evaluate case management approach for complex and vulnerable individuals to provide more holistic, anticipatory and coordinated care.
- One Bromley taskforce and strategic board deliver early intervention and prevention initiatives, including through our new Health 'one stop shop' in central Bromley.
- Delivery of a new Bromley Mental Health and Wellbeing Strategy (see Programme 3).
- Develop a new universal and targeted service offer for children with identified speech and language needs.

Actions for 25/26

- Engagement through neighbourhoods with communities about the root cause of current levels of utilisation of prevention and screening services and self support.
- Explore need for place-based prevention service supporting health checks and management of chronic conditions at scale, embedded in neighbourhoods.
- Support for staff at all levels and across providers to interrogate, manipulate and interpret service and populations data.
- Expansion of use of care closer to home initiatives for more complex areas requiring greater cross boundary working – e.g. Children's hubs: LGBTQ+ and young carers.
- Influencing partners beyond health and care with evidence from engagement.

Intended outcomes in 5 years time

- System partners working together to identify and support the needs identified.
- People identified through population health analysis have more holistic, anticipatory and co-ordinated care, delivering better health outcomes and managing the growth demand on GPs, mitigating hospital admissions and impacting social care costs.
- Population health analysis platform in place.
- Place and neighbourhood teams utilising population health analysis platform to support identifying and engaging populations with higher health opportunity, then monitoring the impact of our actions.
- Neighbourhoods have clear understanding of, and work hand-in-hand with, their communities.
- Reduced demand for specialist services, due to meeting needs at earlier opportunities.
- Increased screening for diabetes, cancer.
- Services amended to better meet needs of our population living with long term conditions, frailty, experiencing health inequalities (Core 20Plus5) and those at risk of emergency admission.
- Earlier support for children and adults requiring mental health support.

Bromley priority action 2 – neighbourhood teams on geographic footprints

Evolve neighbourhood teams into integrated geographic footprints to meet health and prevention needs of the local population: spanning primary, community and social care, with third sector and specialist physical and mental health

Partners have joint understanding of the purpose, function and geographies of neighbourhood teams, and the roles different providers play within them, to target prevention, tackle inequalities and provide appropriate focus for people with more complex needs. Neighbourhood teams are structured to make the best use of time – that of service users, health and care professionals, voluntary and third sector partners – to deliver service-user-led outcomes. Combined with Programme 3, moving resources out of hospitals to the community, we will support the sustainability of our health and care system in the long term.

How we will secure delivery

Actions for 24/25

- Implement new neighbourhood development governance arrangements supporting the core principles of integrated neighbourhood teams.
- Evaluate early initiatives, such as CYP hubs, wellbeing cafés, diabetes outcomes improvement programme to gain and share learning of joint working.
- Start to organically establish organisations' services, staffing and structures commitment to neighbourhoods – including secondary and mental health consultant capacity to neighbourhood working for target clinical specialties.
- Engage local populations in development of services in neighbourhoods.
- Further tools collated and available to support our staff in working cross-system.
- Commence needs analysis and scoping for improved community access to diagnostics and wider primary care services (dentistry, pharmacy and optometry).
- Implement SEL safeguarding work at Place, including through opportunities presented through new multi-agency multi-disciplinary working on neighbourhood footprints.

Actions for 25/26

- Continued development of neighbourhood working and leadership.
- Co-production skills development with neighbourhood teams to set selves up for future development work

Intended outcomes in 5 years' time

- Neighbourhood structures and governance established to a common minimum standard.
- Workforce, finance, data analysis, organisational development, co-design skills and other enablers to support success of neighbourhood teams in their work is established.
- Target clinical specialties secondary and mental health consultant job plans embed neighbourhood working as a means to delivery of secondary care services - aligning services to core teams at different geographical levels as appropriate for the patients' needs.
- Care and health services operating as part of high-trust integrated neighbourhood teams reducing duplication between services.
- A sustainable, accessible and responsive model of integrated primary care operating across all neighbourhoods in Bromley.
- Initial commissioning of services on neighbourhood geographic footprints.
- Reduce need for hospital referral through greater use of community point of care testing, community diagnostics and primary care / community / secondary and mental health MDTs.

Bromley priority action 3 – implement moving care closer to home

Implement our care closer to home programmes across Children's and Young People, Community Mental Health Transformation, Hospital at Home, and disease pathways

Where it is safe and effective to do so, Bromley will move more care into communities and people's homes. This will mean that hospitals are better able to target their resources for patients needing care in those settings, while improving equity of access to care and outcomes for Bromley residents. These place-level programmes to move resources into the community will be delivered with neighbourhood teams. This will involve sharing workforce and developing new ways of working among professional teams and with service-users, carers and families to support people using services more effectively, with self-care and remote monitoring and support, including with third sector partners. These programmes will interface with and support the Bromley delivery of South East London-wide programmes where relevant.

How we will secure delivery

Actions for 24/25

- Children's Integrated Health Teams (B-CHIP) across all PCNs with impact evaluated.
- Consider adult Hospital at Home and frailty provision as part of a holistic community urgent response offer, including working with care and nursing homes.
- Embed new single points of access for blended NHS, voluntary sector and other partner support for CAMHS and adult mental heath services.
- Mobilise new joint Bromley Council/SEL ICB Mental Health Support@Home service for children and adults with long-term and complex health and care needs, including physical and learning disabilities, and mental health.
- Completion of baseline needs assessment of children, young people and adult's mental health needs in Bromley to underpin the development of a new Bromley Mental Health and Wellbeing Strategy (2025-30).
- Establish strategy for integrated end of life care in Bromley focussed on quality and coordination, bringing clarity for organisations and residents.
- Continue localised delivery of transformation programmes for cancer, respiratory, diabetes, cardiovascular and frailty.

Actions for 25/26

- Continue linking working of care closer to home services with emerging neighbourhood teams
- Commence delivery of Bromley Mental Health and Wellbeing Strategy.

Intended outcomes in 5 years time

- Reduction in waiting times for children's health services.
- Improved access to adult wellbeing early intervention and prevention – particularly in cancer, respiratory, diabetes, cardiovascular and frailty.
- A reduction of clients requiring inappropriate/costly residential and nursing care who could be better supported living independently in their own homes.
- A reduction in the need for children, young people's and adults specialist and inpatient mental health services for those who could be better supported by other services.
- A significant reduction in the level of re-referrals and readmissions for people moving between mental health services.
- Reduced need for adults to attend hospital for acute care.
- Improving the quality and experience of end of life care residents and their families, with more people dying in the place of their choice.
- Reallocation of resources to reflect change in where patients are treated.
- Improvement in Bromley ranking in London for recorded depression.
- Improved outcomes for users of all care closer to home programmes.
- Communities feel that they own the services they have supported build through co-design.

Bromley priority action 4 – primary care sustainability

Establish and deliver development plan to support primary care sustainability

Bromley has a well developed model of collaborative working across the local health, voluntary and social care system, under the umbrella of One Bromley. We will continue to develop models to enable enhanced primary care resilience, develop sustainable operating models and work together with other local health and care services through neighbourhood teams. This will support primary care focussed reduction in inequalities and ensure a sustainable, accessible and responsive primary care offer for Bromley residents.

How we will secure delivery

Actions for 24/25

- Develop and agree future model(s) in general practice through continued collaborative transformation approaches, informing community care and urgent care procurement processes. This will include:
  - Share insights and benchmarked outcomes on delivery of primary care across clinical care and patient outcomes at practice and PCN level, e.g. Clinical Effectiveness, QOF, and other data sources for long term condition outcomes.
  - Continue clinical quality improvement implementation: 1) quality improvement methodologies, 2) reviewing demand and capacity, 3) digital transformation
  - Maximise use of existing estate – focus on fit for purpose and appropriate scale
  - One Bromley Strategic Workforce programme, Training Hub and partners collaborate on attracting people to work in primary care in Bromley and new routes into primary care. Develop Portfolio working model for Bromley to attract GPs.
  - Integrating community pharmacy through neighbourhood working, shifting appointments from general practice through Pharmacy First.

Actions for 25/26

- Continue delivery of primary care development programme
- Delivery of identified responses to support health inequalities – e.g. catch-up clinics for screening
- Plans for fit for purpose estates to enable integrated neighbourhood working
- Deployment of resources to support equitable access
- Commence training for staff on how to work cross organisationally as part of joined-up primary care and neighbourhood teams

Intended outcomes in 5 years time

- Primary care on a more sustainable footing and practices more resilient
- Optometry, pharmacy and dentistry part of One Bromley partnership
- Improvement in equality of primary care access
- Improvement in health inequalities outcomes
- General practice working with partner practices and as part of integrated neighbourhood teams

Bromley priority action 5 – integrated urgent care

Coherent system-wide approach to integrated urgent care in a more sustainable model and easier to navigate for professionals and all service users

We will co-develop an urgent health and social care plan across our partnership and with our communities to simplify same day access to physical, mental health, social support and third sector care when it is needed. Our ambition is people receive the right care, in the right place, at the right time - reducing escalation of need and hospital admission, particularly for our frail, elderly and higher users of services. This will mitigate growth in costs to the Bromley health and care budget while supporting the sustainability of our urgent care providers. It will build on, and augment, our current provision to form a highly integrated and responsive model meeting the population needs using resources available.

How we will secure delivery

Actions for 24/25

- Agree between partners and with our communities an improved integrated urgent care model to meet same-day care needs for patients, offering clearer access and enhancing sustainability – working with developing neighbourhood teams to calibrate activities at Place and Neighbourhood level, clarifying role of general practice and meeting seasonal demand.
- Admission avoidance community: consider role of adult Hospital at Home and frailty provision in same day care as part of a holistic community urgent response service.
- Admission avoidance hospital: front door ED streaming, SDEC services with embedded speciality capacity, mandated heralding of professional referrals to ED.
- Expanded High Intensity User and Complex Case Programme working cross system and supported by population health analysis as available.
- Children's hubs across borough support community response, including improved opportunities to understand and respond to safeguarding needs and vulnerabilities.

Actions for 25/26

- Needs analysis and scoping for improved community access to diagnostics and wider primary care services to avoid hospital attendances.
- Utilise emerging neighbourhood teams to support delivery of self care messaging – with supporting collateral e.g. 'when to escalate' booklets for parents, training course for informal carers of people with long term conditions.

Intended outcomes in 5 years time

- Services refocussed on avoiding hospital admission, particularly frail elderly.
- Where necessary, after urgent episode of care urgent services refer patients onto robust community and third sector services.
- Single Community Urgent Response Service in place which avoids hospital for more complex, frail and elderly patients.
- Residents have better understanding of how to best use same day and emergency care.
- Residents, particularly informal carers, more confident in self care, support available to them and when and how best to escalate acute exacerbations.
- Implementation of guaranteed same-day care for patients where identified need.
- Clarified role of general practice in urgent care.
- Clear, timely, accurate handover of patients from hospital to neighbourhood teams.
- Greater utilisation of step-up same day social and third sector care.
- Reduction in ED attendance as part of urgent mental health pathway.
- Providers and commissioners financially more sustainable in delivery of urgent care.
- Reduced need for hospital referral through greater use of community point of care testing and community diagnostics.
- At any 'point of access' health professional access other help rather than re-refer.

Bromley borough – local delivery

Bromley borough delivery of SEL pathway and population group priorities

Bromley is committed to ensuring our population have equitable access and a consistent quality of services in line with our neighbours across the ICS. We are achieving this by embedding delivery of the key ICS pathway and population group priorities in our place and neighbourhood working. We are building on strong foundations of aligned plans in areas including children & young people and management of long term conditions, while localising pathway plans such as cancer and learning disabilities & autism using feedback from our local population. Correspondingly the core principles of prevention and population health management are at the heart of our plans to transform local population outcomes.

UEC: Enhance our integrated out of hospital offer

Through our refresh of the local Integrated Urgent Care Plan, and building on successful high intensity user work to date, we are using population health management segmentation analysis to support engagement with higher users of emergency care to understand drivers of current service utilisation, including across primary and community providers. This will support the realisation of neighbourhood working through understanding needs and building services that meet those needs in more effective ways.

CYP: Integrated Child Health Models

Bromley has commenced roll-out of the Children's Integrated Health Teams, localising the model and evaluating its operating in all PCNs. This brings health and care services together to improve care co-ordination, support for families and reduce health inequalities while bringing care closer to home. The outcomes will demonstrably reduce emergency department contacts, non-elective hospital admissions and increase user satisfaction, in line with ICS ambitions and ahead of ICS-wide timelines.

Primary care: Develop and embed INTs

Building our neighbourhood model and workforce plan is a core plank of evolving our teams into integrated geographic footprints to meet health and prevention needs of the local population: spanning primary, community and social care, with third sector and specialist physical and mental health input. This will be alongside local and ICS agreement on aligning financial and contractual models to support INTs: supporting the shift of organisations' structures and ways of working to neighbourhood footprints.

Palliative & EoL Care: Virtual wards

Bromley Hospital at Home will continue to develop and expand, including considering its role in same day care to better avoid unscheduled hospital attendance for the most vulnerable in our community. This includes piloting the use of ultra-sound point of care testing alongside our existing suite of at bedside diagnostics, and further exploring remote monitoring to identify and respond earlier to signs of deterioration. Our deeply integrated service offers prime opportunity to embed end of life care approaches earlier for more patients.

Bromley enabler requirements (1)

Workforce

- **Support Neighbourhoods plan for and secure the workforce to meet the priorities**
- **Recruitment** (current and future workforce)
  - One Bromley recruitment campaign; One Bromley 'come and work with us' website page on ICS website; Local Recruitment fairs for health and care roles.
- **Retention** (innovative roles, shared roles, wellbeing and skills development)
  - Building staff agreement for joint services; Joint training & wellbeing programmes.
- **System working** (Organisational Development to support wider understanding of the system, working across silos, development of teams employed across the system, system leadership).
- **Widening participation and understanding of careers**
  - One Bromley Springpod, One Bromley Cadet programme.
- **Business intelligence on workforce** – share good practice.

Digital

- **Aligning and integrating systems** used by delivery staff over the medium-long term – to enable effective joined up delivery at neighbourhood level, but requiring action at Place and ICB level to realise this ambition.
- **Securing new tools for clinical staff** – supporting specification development and interdependencies for remote monitoring platform(s) and real-time integrated clinical systems and tools.
- **Clarity on future of non-recurrently funded tools**, e.g. Ardens, Accurex (SMS), e-consult, practice websites.
- **Business Intelligence and shared data** tools made available to local teams to support population health management and clinical decision making
- **Enable mobile workforce**

Estates

- **Local estates planning** with all local partners through the Local Estates Forum, developing the local and primary care estates strategy.
- **Utilisation of estate across Bromley** beyond existing NHS properties, including shared accommodation and hub working.
- **Levering investment** into the Borough to support estates development.
- **Progress the development** of the Bromley Health and Well Being Centre and other capital schemes.
- **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.

Finance

- **ICB supported analysis** - Post-code based analysis and data on NHS and care utilisation, with either place based staff to interrogate, or simple access to SEL based analysis with analytical time for Bromley.
- **Service and programme level reporting** across the system, across providers to support service transformation.
- **Financial support to diagnostics** - Support for greater diagnostic capacity/modality access to community/primary care.
- **Financial support to estates** - Support with capital investment.
- **Consideration to how capacity and capability of VCSE** can be enhanced.
- **Shared financial reporting** across health and social care providers in Bromley to understand the impact of change initiatives on the Bromley pound.

Bromley enabler requirements (2)

One Bromley Culture

- Governance for cross organisational working
  - **Streamlined governance** which supports the building of trust and assurance amongst and between senior leadership teams.
  - **Broaden range of cross One Bromley functional groups** – e.g. Communication and engagement, business intelligence, contracting, strategy leads.
  - **Review what decisions and risk can be held jointly** between partners rather than by each organisation individually.
  - **Review the operational groups** required to enable joined up delivery at place and neighbourhood level, including community voice.
  - **Embedding of One Bromley strategic priorities into organisational priorities**
- Working with SEL partners.
  - **Alignment of Place delegations and resources and decision making authority at Place.**

Communication and engagement

- Communication and engagement **skills training for neighbourhood teams and SEL programme leads** – building asset based community approach.
- **Direct support** to neighbourhood teams community engagement.
- Support building and skilling network of **community champions.**
- **Agreed One Bromley identity and usage requirements.**
- Agreed approach to **internal communication and engagement on One Bromley** and its work programmes.
- **Work hand-in-hand with voluntary, community and social enterprises** as source of insight, intelligence, strategic direction and engagement, especially with marginalised communities.