ONE BROMLEY
WORKING TOGETHER TO IMPROVE HEALTH AND CARE

One Bromley Local Care Partnership Board
Date: Thursday 27 March 2025
Time: 9.30am – 11.10am
Venue: Bromley Civic Centre, the Council Chamber (Phase 1, Floor 0), Churchill Court, Westmoreland Road, Bromley, Kent, BR1 1DP - NEW PREMISES
Chairmen: Harvey Guntrip and Councillor Colin Smith

Members of the One Bromley Local Care Partnership are asked to report any conflict of interest, in respect of any of the following agenda items to Gemma Alborough, Business Support Lead, immediately upon receipt of this agenda.

AGENDA

No	Item	Enclosure	Presenter	Timing
Opening Business				
1.	**Welcome, introductions to the One Bromley Local Care Partnership Board and apologies for absence**	Verbal	Chairmen	09:30
2.	**Declarations of interest**	Enc. 1	Chairmen	09:32
3.	**Public Questions received in advance of the meeting**	Verbal	Chairmen	09:35
4.	**Minutes of the meeting held on the 30 January 2025** For approval	Enc. 2	Chairmen	09:40
5.	**Actions for the Board** For approval	Enc. 3	Chairmen	09:45
For Approval				
6.	**Neighbourhood Development Next Steps** For approval	Enc. 4	Dr Angela Bhan Elliott Ward	09:50
For Information and Noting				
7.	**One Bromley End of Year Achievements 2024-25** For information	Enc. 5	Dr Angela Bhan All	10:05
8.	**Partnership Report** For information	Enc. 6	Dr Angela Bhan	10:20
9.	**Finance Month 10 Update** For information	Enc. 7	David Harris	10:35

Reports from Key Sub-Committees for Noting				
10.	**Primary Care Group Report** For information and noting	Enc. 8	Mark Cheung	10:45
11.	**Contracts and Procurement Group Report** For information and noting	Enc. 9	Sean Rafferty	10:50
12.	**Performance, Quality and Safeguarding Group Report** For information and noting	Enc. 10	Mark Cheung	10:55
Closing Business				
13.	**Any Other Business**	Verbal	All	11:00
Appendices				
14.	**Appendix 1: Glossary of Terms**	Enc. 11	For information	
Next Meeting:				
	The next meeting of the One Bromley Local Care Partnership Board will be held on the 19 June 2025 and will start at 9:30am in Bromley Civic Centre, the Council Chamber (Phase 1, Floor 0), Churchill Court, Westmoreland Road, Bromley, Kent, BR1 1DP – NEW PREMISES			

NHS South East London ICB One Bromley Local Care Partnership Board - Declared interests as of March 2025

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Name	Who do you currently work for	Position/ Relationship with ICB	Declared Interest	Nature of interest	Valid From	Valid To
Dr Hasib Ur Rub	Bromley GP Alliance	Chair, Bromley GP Alliance Member of SEL ICB Committees	Non-Financial Professional Interest	Programme Director for GP Training in Bromley, Health Education England.	01/01/2007	
			Non-Financial Personal Interest	Trustee of World War Muslim Memorial Trust Charity	12/02/2021	
			Financial Interest	Bromley GP Alliance is a provider of some health care services across Bromley.	28/01/2015	
			Financial Interest	Self-employed General Practitioner.	01/01/2020	
			Non-Financial Professional Interest	Vice Chair of RCGP South East Thames Faculty	05/12/2024	
Dr Angela Bhan	South East London ICB	Place Executive Lead for Bromley	Non-Financial Professional Interest	Undertake professional appraisals for UKHSA consultants in public health.	01/07/2022	
			Financial Interest	Very occasional assessor for Faculty of Public Health CESR applications for GMC, on behalf of Faculty of Public Health.	01/07/2022	
			Non-Financial Professional Interest	Professional Public Health advise given to the London Borough of Bromley when required.	01/07/2022	

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Councillor Colin Smith	London Borough of Bromley	Leader of the Council and Co-Chairman of One Bromley Local Care Partnership Board	All interests are declared on the London Borough of Bromley register of interests.			
Councillor Diane Smith	London Borough of Bromley	Portfolio Holder for Adult Care and Health	All interests are declared on the London Borough of Bromley register of interests.			
Dr Andrew Parson	South East London ICB	One Bromley Clinical Lead and Co-Chairman of One Bromley Local Care Partnership Board	Financial Interest	The Chislehurst Partnership - This is a GP partnership which holds an NHS PMS General Practice contract and is a member of the MDC PCN in Bromley. The practice holds a contract from Bromley Health Care for delivery of the Advanced Practitioner Care Practice in Diabetes. The practice is a member of BGPA , a GP federation in Bromley.	01/07/2022	
			Financial Interest	The Chislehurst Partnership is a member and shareholder of BGPA .	01/05/2023	

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			Indirect Interest	Former spouse is employee of Bromley Y which provides tier 2 CAMHS in Bromley.	01/07/2022	
Angela Helleur	King's College Hospital NHS Foundation Trust	Site Chief Executive, Princess Royal University Hospital	Financial Interest	Works as an expert witness in midwifery claims - legacy cases only	01/08/2024	
Paulette Coogan	South East London ICB	Director of People and Systems Development, Bromley	No interests declared			
Mark Cheung	South East London ICB	One Bromley Programme Director	No interests declared			
David Harris	South East London ICB	Associate Director of Finance - Bromley	No interests declared			
Iain Dimond	Oxleas NHS Foundation Trust	Mental Health Lead, South East London ICB Executive	Non-Financial Professional Interest	SRO for the Complex Care Mental Health Programme Group	01/10/2023	
Donna Glover	London Borough of Bromley	Director of Adult Services	No interests declared			
Dr Nada Lemic	London Borough of Bromley	Director of Public Health	No interests declared			

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David Walker	Bromley Third Sector Enterprise	Chief Executive Officer	Indirect Interest	Wife is Business Manager of a medical software company that supplies PROMs to NHS.	03/01/2023	
			Non-Financial Professional Interest	Elected Councillor, London Borough of Lewisham	03/05/2024	
Jacqui Scott	Bromley Healthcare	Chief Executive Officer	Financial Interest	Chief Executive of Bromley Healthcare	01/04/2024	
Sean Rafferty	London Borough of Bromley	Joint Appointee between ICS and LBB; Chair of Bromley Contracts and Procurement Group	No interests declared			
Jan Noble	St Christopher's Hospice	Interim Chief Executive	No interests declared			
Harvey Guntrip	South East London ICB	Lay Member for Bromley	No interests declared			
Helen Norris	Healthwatch	Healthwatch Bromley representative	No interests declared			
Dr Ruth Tinson	Bromley LMC	Chair	No interests declared			
Dr Hannah Josty	Bromley LMC	Vice Chair	No interests declared			
Christine Harris	South East London ICB	PA/ Business Support- Bromley	No interests declared			
Gemma Alborough	South East London ICB	Business Support Lead – Bromley	No interests declared			

NHS South East London ICB One Bromley Local Care Partnership Board - Declared interests as of March 2025

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Dr Claire Riley	Orpington PCN	Orpington PCN Clinical Director, GP Partner Green Street Green Medical Centre, One Bromley PCN Clinical Lead Strategy, Interface and Neighbourhoods	Financial Interest	GP Partner at Green Street Green Medical Centre, practice is member of Orpington PCN. The practice is also a member and shareholder in BGPA.	01/01/2013	
			Non-financial professional interest	Clinical Director Orpington PCN.	01/11/2022	
			Indirect Interest	Spouse is Associate Director of Wilkinson Eyre Architecture firm who occasionally tender for public building design in the healthcare sector.	04/10/2009	
Dr Bridget Hopkins	Stock Hill Surgery Five Elms PCN	GP Partner, Stock Hill Surgery PCN Clinical Director, Five Elms One Bromley PCN Clinical Lead Strategy, Interface and Neighbourhoods	Financial Interest	GP Partner at Stock Hill Surgery	05/10/2018	
				Practice is a member of Bromley GP Alliance	04/02/2000	
			Indirect Interest	PCN Clinical Director, Five Elms PCN	2023	
Amanda Mayo	St Christopher's Hospice	Care Director	No interests declared			
Charlotte Bradford	Healthwatch Bromley	Operations Co-ordinator	No interests declared			

ENCLOSURE: 2
AGENDA ITEM: 4

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One Bromley Local Care Partnership Board
Minutes of the meeting on 30 January 2025
Held in The Council Chamber, Bromley Civic Centre

Present:

Name	Title and organisation	[Initials]
Members (Voting):		
Dr Andrew Parson	One Bromley Senior Clinical Director (Co-Chairman), South East London ICB	AP
Cllr Colin Smith	Leader of the Council (Co-Chairman), London Borough of Bromley	CS
Richard Baldwin	Director of Children's Services, London Borough of Bromley	RB
Dr Angela Bhan	Bromley Place Executive Director, NHS South East London	AB
Iain Dimond	Chief Operating Officer, Oxleas NHS Foundation Trust	ID
Donna Glover	Director of Adult Services, London Borough of Bromley	DG
Harvey Guntrip	Bromley Borough Lay Member, NHS South East London	HG
Dr Bridget Hopkins	Clinical Director, Five Elms PCN	BH
Dr Nada Lemic	Director of Public Health, London Borough of Bromley	NL
Jan Noble	Interim Chief Executive, St Christopher's Hospice	JN
Dr Claire Riley	Clinical Director, Orpington Primary Care Network	CR
Cllr Diane Smith	Portfolio Holder for Health and Care, London Borough of Bromley	DS
Dr Hasib Ur-Rub	Chair, Bromley GP Alliance	HU-R
David Walker	Chief Executive Officer, Bromley Third Sector Enterprise	DW
Members (Non- voting):		
Mark Cheung	One Bromley Programme Director, NHS South East London	MC
Paulette Coogan	One Bromley People and System Development Director, NHS South East London	PC
Dr Hannah Josty	Vice-Chair, Bromley Local Medical Committee	HJ
Sean Rafferty	Joint Assistant Director of Integrated Commissioning, NHS South East London and London Borough of Bromley	SR
In Attendance:		
Gemma Alborough	Business Support Lead - Bromley, NHS South East London	GA
Dr Jon Doyle	Clinical Director, One Bromley	JD
Georgina Feleke	Non-Executive Director, NHS South East London	GF
Christine Harris	PA/Business Support – Bromley, NHS South East London	CH
Fiona Leacock	Head of Quality – Bromley, NHS South East London	FL
Helen Marsh	Head of Communications & Engagement – Bromley and Lewisham, NHS South East London	HM
Rachel Riley	Organisational Development Project Lead, One Bromley	RR
Elliott Ward	Associate Director, Strategy Development and Delivery, One Bromley	EW
Observing:		
Sarah McCombie-Brown	Bromley Primary Care Networks Co-Ordinator	SM-B

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Apologies:

Members (Voting):

Angela Helleur	Site Chief Executive, Princess Royal University Hospital and South Sites, King College Hospital NHS Foundation Trust	AH

Members (Non-voting):

Helen Norris	Chair, Bromley Healthwatch	HN
Dr Ruth Tinson	Chair, Bromley Local Medical Committee	RT

In Attendance:

David Harris	Associate Director of Finance, NHS South East London	DH

		Actioned by
1.	**Welcome, Introductions to the One Bromley Local Care Partnership Board & Apologies for Absence**	
1.1	Councillor Colin Smith welcomed members and attendees to the One Bromley Local Care Partnership Board.	
1.2	Apologies for absence were noted as recorded above.	
2.	**Declarations of Interest**	
2.1	The declaration of interest register was noted, there were no additional declarations made in relation to items on the agenda.	
3.	**Public Questions**	
3.1	No questions had been received.	
4.	**Minutes of the One Bromley Local Care Partnership Board Meeting 28 November 2024**	
4.1	The minutes were **APPROVED** as an accurate record of the meeting.	
5.	**Actions for the Board**	
5.1	The action log was reviewed, all actions were complete.	
5.2	The Committee **NOTED** the action log.	
6.	**Bromley Primary and Secondary Care Interface Consensus**	
6.1	Dr Bridget Hopkins introduced the item, the slides were taken as read. The interface is the point of interaction between complex and busy systems. Colleagues are committed to improving access to primary care for all patients by working together and making changes specifically to improve the patient journey. The One Bromley Local Care Partnership Board were asked to endorse this ongoing work. Dr Claire Riley noted that in 2023 ICBs were directed to address four key areas of the interface: • Onward referrals • Complete care (fit notes and discharge letters) • Call and recall • Clear points of contact Colleagues have worked with general practice and the Princess Royal University Hospital (PRUH) and established a Task and Finish Group to address these areas, with outcomes reported to the One Bromley Clinical and Professional Advisory Group (CPAG) which has clinical membership from all organisations in the local system. There has also been wider engagement	

	within the South East London (SEL) Interface Group, which includes representation from Healthwatch, bringing the patient voice into discussions. An interface document had been progressed locally, which agreed a set of standards to define how general practice and the PRUH will work together for the benefit of patients. There had been recent meetings with Bromley Healthcare and colleagues have reached out to St Christophers and Oxleas to try and improve the interface for patients across the broader system. Dr Jon Doyle gave thanks to the Board for giving time on the agenda for this item. This is an important piece of work primarily looking at the interface between two complex systems, leading to improvements for both staff and patients. Regular feedback is given to SEL. There had been good engagement throughout and there was pride in the momentum gained. Colleagues would report back to the Board again at a later date.	
6.2	In considering the item, Board members had the following comments: • Dr Parson thanked presenters and opened for questions. • Jacqui Scott noted that this an exemplary piece of work, the impact of which can already be seen. Feedback from the Bromley Healthcare team had been positive. • Harvey Guntrip noted that there have previously been issues with engagement between staff in different parts of the system. It was asked if this had improved since starting this work. It was noted that discharge letters do not appear in the NHS application, meaning that GPs may not have had sight of details when patients contact them post discharge. It was asked if this is a common issue and if there was a possibility this may improve. • Iain Dimond noted it was good to see the pack and the structured systematic approach. Oxleas welcomed the broadening of scope and noted that relationships between primary care and Oxleas had improved greatly over time and that this would only enhance that further. • Dr Ur-Rub praised this excellent work and asked about the sustainability of change that occurs, particularly at the acute trust where there are regular changes to personnel within departments. It was queried as to whether there is an opportunity for primary care to be involved in the induction process for incoming new doctors and whether this would encourage understanding of primary care and improve communication. • Dr Riley responded to Harvey Guntrip's comments, noting that whilst the Task and Finish Group meetings had a relatively small membership, a series of round table events had been held which colleagues from all departments at the hospital and wider primary care had been invited to. Relationships had started to be built, with an acknowledgement that staff in all parts of the system are working really hard, with the common aim to join together for the benefit of the patient. • Dr Doyle added that the Task and Finish Group has offered an opportunity to raise issues, with subsequent meetings held with directorates to look to address these and make tangible improvements. • Dr Hopkins noted the valid points raised by Dr Ur-Rub and confirmed that a meeting had been arranged with the Chief Medical Registrar at the PRUH to look to move forward with inductions for junior doctors. • Dr Riley noted there is ongoing work on discharge letters and DOCMAN, the process that enables letters to be received into GP notes. A GP Trainee is working on that project, to consider how digital paperwork gets into patient records. Patients can view their letters via MyChart before GPs can	

	view them on the NHS patient record. Dr Riley noted the frustration for both patients and clinicians. • Dr Angela Bhan reiterated the benefits that patients themselves will feel. A lot of the discussion had been on the ease of working between health professionals, but the point about the join up of applications was important. Improving the primary and secondary care interface will lead to more joined up care. When patients are discharged, they will also start to have a more positive experience, with less bureaucracy and a smooth transition between care in different parts of the system. • Harvey Guntrip noted that historically upon discharge there has been a lot back and forth and a lack of clarity of who the patient should contact. It was asked if this would now improve. • Dr Hopkins noted that one of the key areas of work is points of contact, this is in progress, however there is a way to go. Patients need a point of contact at the hospital rather than going back to primary care. • Dr Doyle noted that there had been some quick wins, with tangible benefits for patients including the example of Med Three sickness certificates which had previously commonly been referred back to primary care for issue upon discharge. These were now produced by the hospital as part of discharge processes. The team are also looking at ways for patients to be directed to self-referral or direct referral pathways before they leave the hospital, to avoid a time lag when trying to see another healthcare professional. • Dr Parson noted that this work is important, it is often looking at the minutiae of things such as medical certificates but makes such a difference to individual patients and their journey. Dr Bhan and Angela Helleur had sponsored this work, it was important to raise the profile of this area as it is both a national and regional initiative. The work done in Bromley is leading the way for SEL. The ability to get a consensus and agreement as a basis is key. Dr Parson encouraged Board members to continue to promote this work. It was suggested that colleagues also reach out to Healthwatch and the voluntary sector. It was asked that an update on progress come back to this meeting once the consensus document was published.	
6.3	The Committee **ENDORSED** the Bromley Primary and Secondary Care Interface Consensus.	
7.	**Neighbourhood Working in Bromley - Update**	
7.1	Dr Parson noted that the previous item was an important enabler for this work. Neighbourhood working requires good professional relationships and integration. The paper was for information and was taken as read, providing an update on the work undertaken by the Executive. Bromley has a strong history of working together for the benefit of our residents. Projects have included Bromley's Children's Health Partnership, Hospital at Home services and the Proactive Care Pathway amongst others. This has brought different forms of expertise together to tackle issues that single organisations cannot. Each exemplifies the One Bromley Strategy focus on prevention, proactive care, more coordinated care and moving more care into the community. Residents have provided positive feedback about this approach, it feels more personal, is more local to home and often provides expert support far quicker than traditional models of care. Getting this right in the long term should further drive the shift from higher to lower cost parts of the health and care system, whilst improving outcomes for residents. The next stage of development, neighbourhood working, sees multiple	

	organisations working together for residents. The Executive has articulated this as different tiers, ranging from hyperlocal to whole borough working. A key tier will be Integrated Neighbourhood Teams (INTs), which are anticipated to become experts in managing complexity outside of hospital and institutional care. Simultaneously spotting this complexity early, to include loneliness, carer stress and managing multiple children with illness at the same time, along with improving connections between residents and services and within communities. Coordinating the expertise from different agencies and professionals would also be key to enabling people to stay and die well at home. The Executive has considered the footprints of INTs and agreed a set of four, which already have currency with many of the existing local authority and provider service footprints. This is balanced with centres of population and natural communities that have built up over decades in Bromley. Central to this approach is the alignment of existing services, whilst taking the opportunity to engage staff in the approach to care delivery and residents in aspects of how specific multiagency services best meet local needs. The Board was asked to continue to provide support and scrutiny to this work, ensuring it meets the needs of the Bromley patient population we serve.	
7.2	In considering the item, Board members had the following comments and questions: • David Walker highlighted that the voluntary sector operates at all levels within the tiers, particularly at tier 4 with whole borough services provided, such as hospital discharge support with Bromley Well, support for neurodiverse people through Casper and Mencap. Bromley Well Single Point of Access (SPA) also occurs at that level. It was asked that this be noted and expressed in future iterations of the presentation. • Iain Dimond noted that this approach is resonating with Oxleas colleagues and that the tiered approach made sense. It was asked how this is being connected with communities themselves. It would be good to hear more about this and how residents are being involved on the journey as the model develops. • Elliott Ward responded that these were important points. It was key to ensure visibility and involvement with all partners around the table. It was noted that it was vital to engage with our communities, on the things that we can do and change. When we look at services which need to bring together multi-agencies to solve a locally specific problem, it was important to look at the unique variances in each part of the borough to ensure this is a neighbourhood intervention. The advice of this committee would continue to be sought as this work progressed. • Dr Bhan noted that engagement with the population and patients is especially important. There are two broad ways that we are doing this, firstly through general events where we invite members of the public to contribute. Specific work is also being undertaken when developing individual pathways, with feedback mechanisms included during and after a service is created or amended. • Paulette Coogan noted that we have not forgotten engagement with patients, we are starting to talk to staff about this to consider the benefits for our residents and the health and care system. A seminar would take place today and next week with wider organisations to consider the key areas we need to focus on. It is recognised that some areas will be undertaken at a borough level whilst others will be more local. Feedback	

from residents would be reported back to this meeting as this work developed.

- Mark Cheung noted that working with communities and partners was key. For the last couple of weeks we have been collaborating with local authority and library colleagues. join in sessions were put together for communities to attend, working with PCNs, this encompasses our ethos of One Bromley partnership working.
- Dr Ur-Rub followed on from Iain Dimond's point, and asked are we developing these pathways and services because these are what our community needs or are we taking our ideas to communities to get feedback. There is a difference between these two approaches, and it was important to consider public health and other data as part of this. Neighbourhood working is about what the neighbourhoods feel their needs are and not what healthcare believe these to be, Dr Ur-Rub believed there is a big difference between the two and felt this did not come out through the presentation. Dr Ur- Rub noted that it is essential that we understand what neighbourhoods are about.
- Harvey Guntrip noted Elliott Ward's point about differentiation in areas within the borough. It was asked how we are looking at inequalities, diversity and ethnicity within hyperlocal areas as part of developing this work.
- Iain Dimond had been thinking about these aspects, noting that Dr Bhan had highlighted the importance of articulating the benefit of this localised approach for residents. This is connected to the second point, and the need for conversations. There will be members of the public who have spotted a need for something which may be a determinant on health, it was asked what the mechanisms are for levering something from these insights and help us to determine priorities for the population. This is complex, but we need to try and maximise the benefits of working at a local level.
- Dr Bhan thanked colleagues for the pertinent questions and comments on why we are doing this. There would be further discussion in the private seminar later this afternoon. It is important to understand that this is not just the health service and colleagues rearranging services, this is for the benefit of patients. The discussion we have had on engagement with the public is important. We are not starting from a blank piece of paper but rather building on what we have in place and how these services are delivered. We can get feedback whilst being realistic about financial constraints. We need to engage with communities to get feedback and an understanding of need. The system has worked together to undertake a huge amount of work on reducing inequalities, for example the Integrated Children's Hub, which has produced expert children's services in each of the PCNs and ensured there is an equivalence of service for each population. The work we have jointly done on winter has also built the platform for neighbourhood working. The Winter Illness Hubs have reduced A&E attendances, and the virtual ward has reduced the need for people to be in hospital and shows that we are helping people to access care closer to home. This work is by no means finished; this presentation sits over a lot of detailed programmes which underpin the approach. It would be helpful to bring back some of these pieces of work to highlight different areas and how we are engaging with the public and reducing inequalities.
- Dr Parson noted that we are going to take stock and discuss this further and that this is an iterative process. Dr Parson agreed with Iain Dimond's point that communities are often undertaking groups and programmes

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	themselves to address issues, that we may not already be aware of. It was important to raise the profile of this local work and bring it to life. This had been a helpful discussion; Dr Parson gave thanks for the update.	
7.3	The Committee **NOTED** the neighbourhood working update.	
8.	**Partnership Report**	
8.1	Dr Angela Bhan introduced the Partnership Report. The following topics were highlighted: • Dr Bhan took the report as read, noting that this reflects the good work going on in Bromley, as well as some of the challenges that remain for organisations and joint working. Colleagues were invited to answer any questions. There is one item not included in the ICB section, relating to procurement for the 111 service and Integrated Delivery Units in all six boroughs across South East London. This procurement has been postponed by a year whilst we await guidance from NHS England on the shape of the 111 service. All boroughs would be looking at what elements of Integrated Delivery Units they can progress with in the meantime.	
8.2	In considering the report, Board members had the following comments: • Jacqui Scott highlighted that the One Bromley Hospital at Home service had received praise from a patient's relative, who had phoned into LBC and given an account of how fantastic the service was and that there should be one in every part of the country. This validated the direction of travel towards neighbourhood teams and care in the community. • Dr Parson noted that there is lots to celebrate in the Partnership Report, to include the award given to Orpington PCN pharmacy team.	
8.3	The Committee **NOTED** the Partnership Report.	
9.	**Month 8 SEL ICB Finance Report**	
9.1	Mark Cheung presented the Month 8 2024/25 Finance Report, which was taken as read. The following highlights were noted: <u>SEL ICB Month 8 Financial Position</u> • As of month 8 the SEL ICB is forecasting that it will deliver a year-end position of break-even. <u>Bromley ICB/LCP Month 8 Financial Position</u> • It was forecasted that we are going to meet our financial target for the year 24/25. • There have been significant pressures around mental health placements and continuing care, with a number of patients having high care needs. These overspends have been mitigated by underspends in corporate budgets and prescribing. Bromley is the only borough underspending on prescribing within SEL, this is due to work undertaken by the Medicines Optimisation team, GPs and the benefits of some drugs coming off patent which has reduced costs. • In looking at the next financial year, planning guidance is expected by the end of the month. This would set out expectations around planning and on funding uplifts. There has been a lot of messaging and information highlighting that next year will be extremely challenging for the NHS, mirroring other parts of the public sector. Once guidance had been received an update on the impact on local budgets and services would come back to this meeting.	

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9.2	In considering the report, Board members had the following comments: • Councillor Colin Smith gave compliments to the hard work and responsible budgeting of all involved locally. Leading on from this, in looking at next year's budget it was asked how clear we are that just because we are within budget, we are not seen to be overfunded, with money potentially moved elsewhere. It was asked what safeguards we have; Councillor Smith would be irritated if our budget was to be cut to balance other area finances. • Mark Cheung responded that we have a process on how budgets are set, and we are clear that we must ensure that Bromley gets its share. There are clear expectations on what we should be getting, with discussions undertaken at Board level between SEL and Bromley colleagues including Dr Bhan. The place team work hard to ensure a robust discussion on ensuring fair resource allocation in the borough. • Councillor Colin Smith noted that this offered some reassurance but asked that colleagues contribute to discussions with SEL before decisions are made and that he was willing to provide his support to any robust discussions needed. • Mark Cheung thanked Councillor Colin Smith for the support offered. • Jacqui Scott noted that the planning guidance is due out today and asked if there had been any early modelling around the size of the financial gap for Bromley and what the plans are to address this and any areas affected, or if it was too early to tell. • Mark Cheung responded that SEL were putting together some modelling with input from colleagues at place. Once this was finalised, it would be brought back to the Board for discussion. • Dr Parson noted the extremely challenging financial landscape for next year.	
9.3	The Committee **NOTED** the Month 8 Finance Update.	
10.	**Primary Care Group Report**	
10.1	Harvey Guntrip took the report as read and welcomed any questions. There were no questions or comments raised.	
10.2	The Committee **NOTED** the Primary Care Group Report.	
11.	**Contracts and Procurement Group Report**	
11.1	Sean Rafferty took the report as read, there were no questions or comments raised.	
11.2	The Committee **NOTED** the Contracts and Procurement Group Report.	
12.	**Performance, Quality and Safeguarding Group Report**	
12.1	Harvey Guntrip noted this had been a good year, with development of the Committee progressing well.	
12.2	The Committee **NOTED** the Performance, Quality and Safeguarding Group update.	
13.	**Any Other Business**	
13.1	There was none raised.	
14.	**Appendix 1: Glossary of Terms**	
14.1	The glossary of terms was noted.	
15.	**Date of Next Meeting:** Thursday 27th March 2025 at 09.30am	

ENCLOSURE: 3
AGENDA ITEM: 5

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One Bromley Local Care Partnership Board – Action Log

Log no.	Action point	Date raised	Responsible	Due Date	Status	Comments
There are no open actions for the Board as of March 2025.						

ENCLOSURE: 4
AGENDA ITEM: 6

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One Bromley Local Care Partnership Board

DATE: Thursday 27 March 2025

Title	**Neighbourhood Development Next Steps**
This paper is for **information**	
Executive Summary	South East London ICS Board has agreed the attached neighbourhood framework, which was built from Place approaches to the purpose and development of neighbourhood working. This is in-line with our approach in Bromley, and provides a long-term vision into which our more recent work on immediate next steps docks. Within Bromley, workshops in January and February 2025 with the Local Care Partnership Board and One Bromley Executive and colleagues focussed on developing the 'why' and initial 'what' of Integrated Neighbourhood Teams (INTs) in Bromley. There was agreement that INTs in Bromley will initially be focussed on real problems faced by our residents and organisations where coming together in a multi-agency and multi-disciplinary way delivers better outcomes for the same or reduced financial cost to the Bromley pound, and mitigates impacts of growth. The initial areas of focus will be: • **Adult** – people living with frailty, multiple long-term conditions and/or being discharged from hospital to the care of services in the community. Focussing on early identification and planning, linking with the right self-help, voluntary, social and health services, and co-ordinating interventions for those who would benefit from this the most. • **Children and Young People (CYP)** – moving beyond Bromley Child Health Integrated Partnership (B-CHIP) initial focus on general paediatric referrals to secondary care. Learning from our development of our multi-agency Adult Hospital at Home service we are utilising a Delphi methodology to move forward our INTs. The development will build on the existing structures and approaches to cross organisational working already in use across One Bromley, while looking to regional and national developments to enhance our approach. To support this, One Bromley Executive has requested: - A communications pack which all One Bromley organisations can use with the own staff - For each organisation to start articulating their own role in INTs

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	- Terms of Reference for a Bromley INT Development Group to hold the detailed development of INTs on behalf of the Executive - Reviews to support learning and alignment of how some existing multi-agency arrangements operate in terms of 1) cross system working 2) contracting 3) fit with INT approach - Place policy leads to further work up a set of 'must dos' for our initial adult and CYP lens for INTs which will be taken into a set of workshops at INT level to operationalise the plans. The immediate next visible step for colleagues across Bromley will be workshop sessions in each INT footprint to move forward the 'must dos' – with each workshop focussed on how, in that INT's context, the ambition is realised. This is anticipated to prompt deeper local engagement with communities and partners. The attached provides the One Bromley communications pack which all One Bromley organisations are asked to utilise.	
Recommended action for the Committee	• Note the South East London ICB neighbourhood framework and be assured that Bromley is operating in line with this framework. • Affirm for Bromley the importance of working together in Integrated Neighbourhood Teams for and with our communities to tackle real-world challenges where a multi-agency, multi-professional approach can provide better outcomes for the same or reduced cost to the Bromley pound, and mitigates impacts of growth. • Champion and discuss the INT approach in Bromley with your teams, supporting the set-up of our initial neighbourhood level development sessions in the next quarter.	
Potential Conflicts of Interest	All parties of One Bromley continue to discuss and develop plans in the best interests of residents and patients. The development of neighbourhood teams may, depending on the approach chosen, require more rigorous conflict of interest management.	
Impacts of this proposal	Key risks & mitigations	Risk: there is a risk that the recently announced re-organisation in the NHS impacts capacity and priorities, delaying INT implementation. Mitigation: There is no change to the policy direction on INT development. We will continue to use INT development to deliver service and efficiency improvements for the people of Bromley.

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	Equality impact	As a key deliverable of the One Bromley Strategy this work aims to improve equity of outcomes for residents of Bromley. Individual teams and work proposals should conduct an equality impact assessment as the work develops.
	Financial impact	Resources and incentives will need to be assessed and aligned in accordance with model design with form following function.
Wider support for this proposal	Public Engagement	Public engagement was undertaken through the development of the One Bromley Strategy, and the ambition is to continue this through development of delivery programmes.
	Other Committee Discussion/ Internal Engagement	• The strategic content has been taken at One Bromley Executive, Health and Wellbeing Board and Bromley Local Care Partnership Board throughout 2024, and subject to further agreement at One Bromley Executive in December 2024. • In January and February we held workshops with the One Bromley Local Care Partnership Board and One Bromley Executive focussed on developing the 'why' and initial 'what' of INTs in Bromley. • One Bromley Executive has approved the Bromley INT communications pack for use with staff and stakeholders.
Author:	Elliott Ward, Associate Director, Strategy Development and Delivery, One Bromley	
Clinical lead:	Dr Andrew Parson, Co-Chair, LCPB	
Executive sponsor:	Dr Angela Bhan, Place Executive Lead	

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Developing Integrated Neighbourhood Teams in Bromley

Communications pack

March 2025

Overview of neighbourhood working in Bromley

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Vision for Neighbourhood Working

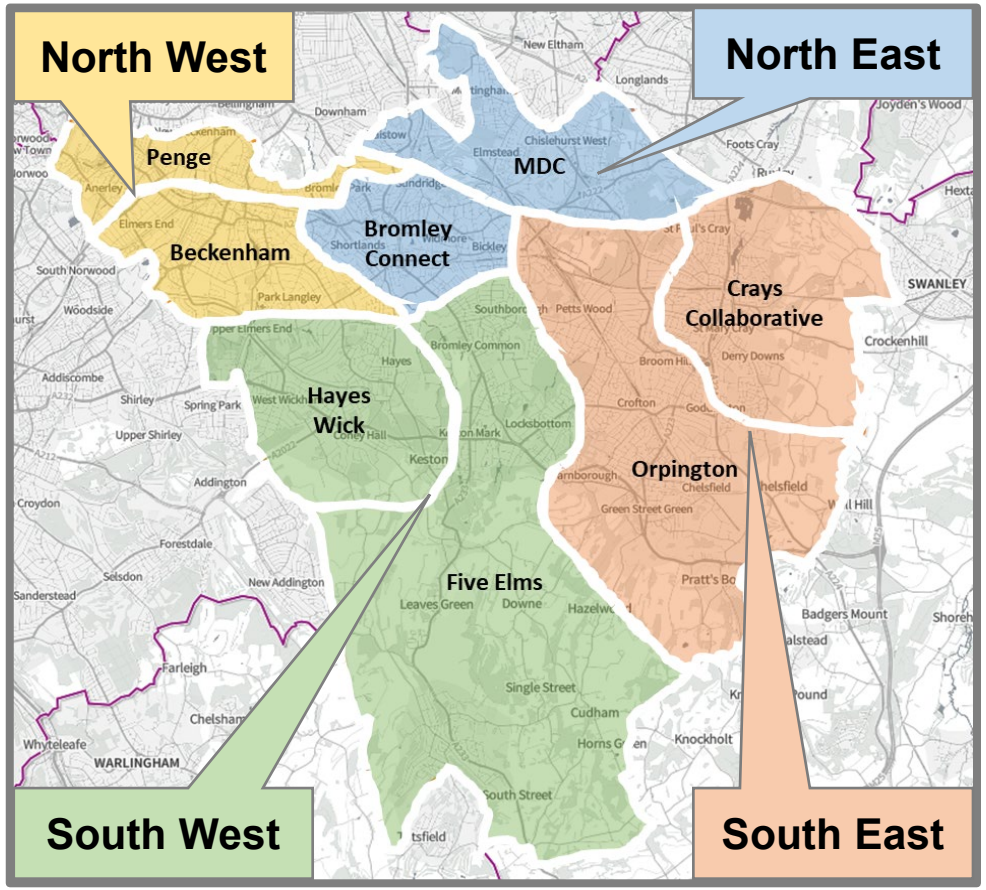
Working cohesively to deliver integrated services across health, social, voluntary and community organisations. These provide holistic, person-centred care, with a focus on prevention and care closer to home embedded in local communities. This approach will make it easier for residents to access and navigate support and lead to improved health and wellbeing for the Bromley pound.

Benefits for Patients

- A more holistic care experience through integrated services
- Improved access to care
- Greater continuity of care
- Easier navigation of the health and care system

Benefits for Staff

- Increased innovation and collaboration
- Greater ability to drive better outcomes
- Opportunities for personal development and enhanced job satisfaction



INT footprint geographies

What is shaping the neighbourhood dialogue?

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POLITICAL SPOTLIGHT

Government priority to transform the NHS into a 'neighbourhood health service' via 3 shifts:

- hospital to community
- analogue to digital
- sickness to prevention

Ongoing publicity will build an expectation of change amongst the public

SOUTH EAST LONDON STRATEGY

South East London are responding by setting out 'neighbourhood working' plans that commit to this direction of travel

It will become part of regular dialogue between system and partner colleagues

RESIDENT NEEDS

The neighbourhood approach has been shaping work locally for some time, we've been building a picture of needs via both data and engagement

We need to consider what our residents want or need to know about our approach, and when we share it

OTHER CONSIDERATIONS

This a long journey, requiring flexibility, elements of 'test and learn', and development over time. At the outset, it is the psychological and cultural shift, and a willingness to work differently, that will be vital.

What is our vision in Bromley?

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Working cohesively together in our neighbourhoods to deliver a holistic person-centred experience with a focus on prevention and support closer to home.

We will achieve this by:

- ensuring our knowledge of the whole person, the strength of their social networks, and the support, services and inequalities present in their communities, is at the centre of our proactive planning.
- our commitment to providing joined up health, social and voluntary sector support that delivers better health and wellbeing for our residents.

What is an INT?

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An **Integrated Neighbourhood Team (INT)** is a group of health, social care and third sector colleagues working together locally to provide seamless, holistic care. Unlike many of our current models, INTs focus on building ongoing relationships with residents, ensuring care is proactive, personalised, and coordinated.

Key emphasis of INTs:

1) **Relational Care**: Continuous, relationship-based care rather than episodic interactions.
2) **Holistic Approach**: Understands people's bio-psycho-social needs.
3) **Proactive**: Focuses on early identification, intervention, prevention and de-escalation.
4) **Coordinated**: Health, social and third sector service staff working together to meet people's needs.
5) **Community-Centric**: Involves and connects residents with local community resources.

This approach links population understanding with personalised, efficient and preventative care.

INT: Focus on co-ordinating expertise

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- Think of a big orchestra – each player has a score of their own part
- No part or instrument is more or less important than the other
- These parts add up to a whole, written in the conductor's score and co-ordinated by them

What does this mean for ways of working in INTs:

- A lead on behalf of our care and health system co-ordinating different services around an individual
- Recognising not every resident will need everything in a standard way: they need what's right for them
- We need to be *orchestrated* around the resident or patient we are working with

Photo (c) Andy Paradise https://vasilypetrenkomusic.com/2863-2/

INT: Focus on prevention

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- INTs are also about getting on the front foot.
- Take Gipton Fire Station in Leeds. 30 years ago it received 10,000 call outs per year to fires. By the time it closed in 2014 it received 300 calls a year.
- Its firefighters were not just experts in putting fires out, but experts in why, in their local area, fires start. They built relationships to tackle those root causes, reduced fires and saved lives.
- In health, this is and feels more difficult. But doing more of the same won't tackle the root causes of some of the bigger challenges we face.
- INTs offer us a way to change what we do and to do it with our communities.
- Gipton Fire Station is now the home of many different community groups – including an INT.

https://www.new-vision.co.uk/case-studies/the-old-fire-station/

Expertise working together

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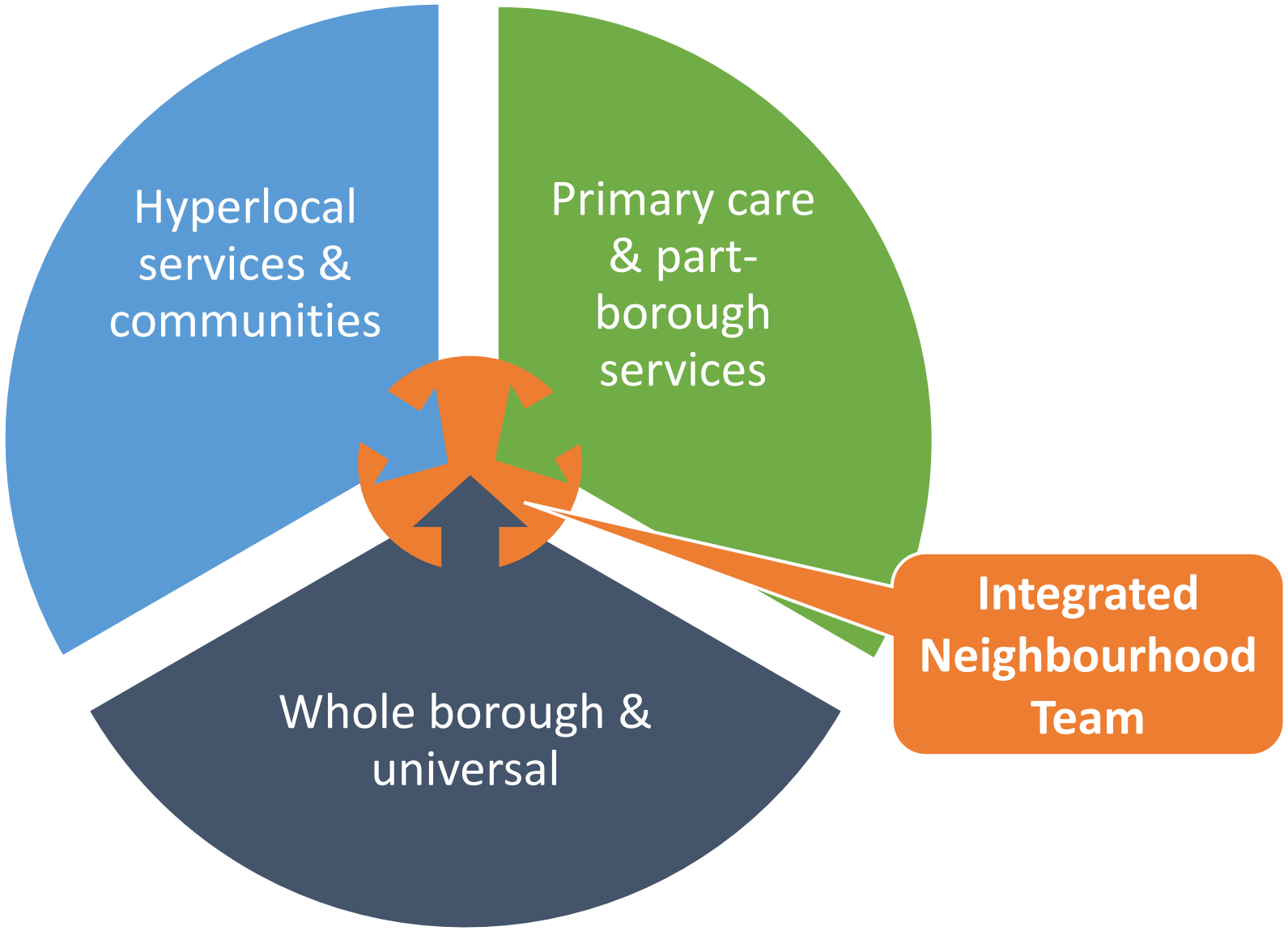

- INTs are centred on utilising resources from communities themselves, the voluntary and community sector, social care, mental health, primary care, community services, public health, secondary care and others.
- Expertise is pulled into the INT space to solve ‘problems’ for the resident or neighbourhood.
- Some teams will work in an INT every day, some will ‘attend’ for sessions each week or month, and some may be part of the wider network.

INTs: What will change?

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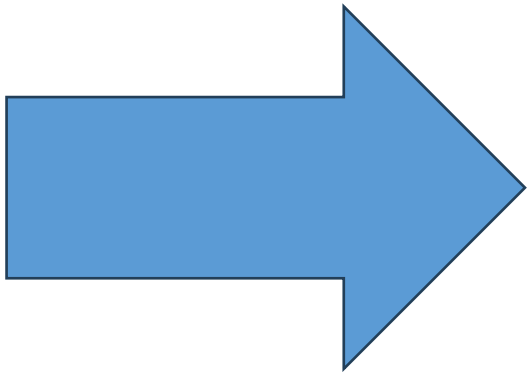
Current service model

- ❖ Referral-based
- ❖ Reactive
- ❖ Transactional
- ❖ Single task



Future service model

- ✓ Relational
- ✓ Proactive
- ✓ Co-ordinated
- ✓ Holistic

Our starting point

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National guidance envisages INTs encompassing much of what social and health care cover currently. We need to start with something manageable to ensure the safety of our services and that we build together with our staff and communities.

Our intention is to build on our existing adult and children's MDT arrangements:

Adult	Children and Young People
Focus: population who are frail, have 3 or more long term conditions and/or are being discharged from hospital back to the care of community-based services	**Focus:** to be refined with CYP leads across One Bromley, focused on key challenges

Next steps

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We will bring together the leads from relevant teams in our four INT footprints to start getting to know one another and build new ways of working for our adult and children & young people priorities for INTs.

South East London
Integrated Care System

Developing our shared approach to Neighbourhood development

Board Papers

January 2025

South East London Integrated Care System

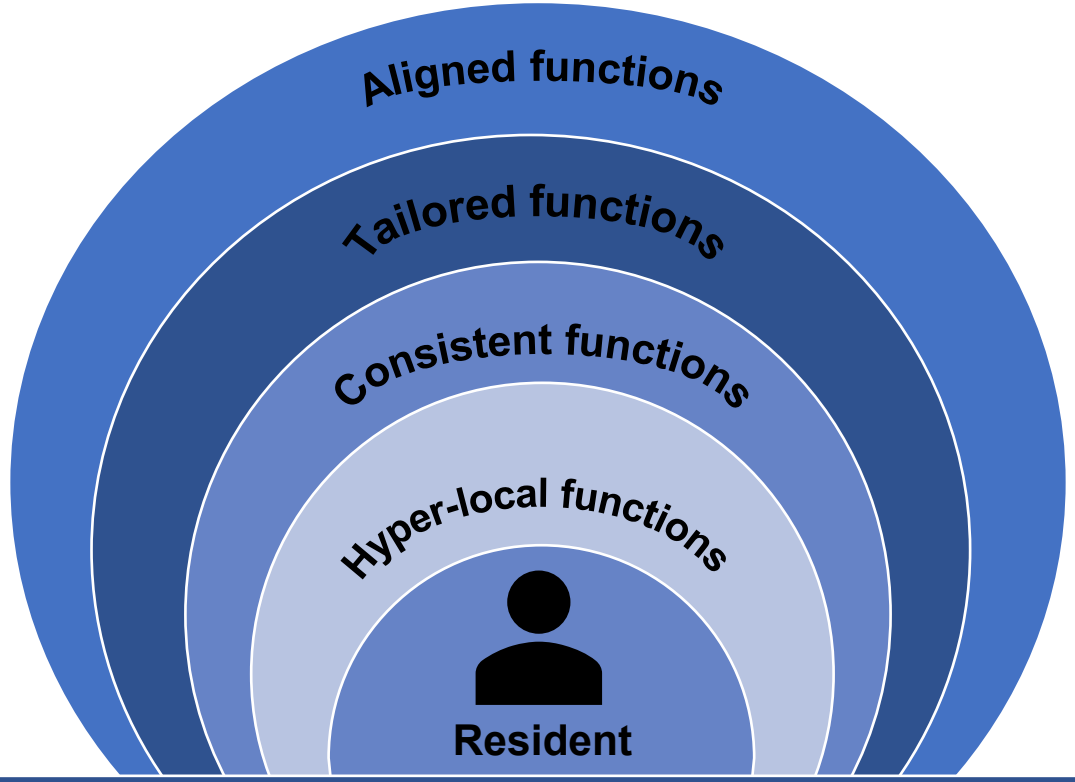
NHS South East London

INT delivery framework

Components of our SEL INT Framework

South East London Integrated Care System

Our SEL INT Framework outlines a shared approach to INT development across Places, and a way in which SEL can increase the proportion of resources used to support people to stay well for longer, and release capacity which is reinvested to scale the model sustainably.



SEL INTs will be underpinned by a number of key ingredients, including a population health management approach and the recognition that we will have to 'test and learn' our approach as INTs develop to ensure they meet population health needs effectively.

Underpinned by key ingredients:

- Organisational development to enable culture shift for system-wide way of working
- Population health management approach
- Shared, clear metrics
- Test and learn approach
- Robust leadership and shared governance
- Interprofessional training infrastructure
- Overarching quality management system
- Alignment with partner and system priorities
- Interoperable digital tools and knowledge
- Contractual mechanisms and human resources (HR) infrastructure to allow joint working
- Geography principles to ensure organised around population needs

What this framework is (and what it is not)

The framework set out is…

- **An overarching structure for INTs across SEL**, providing 'enough' structure to ensure we deliver consistently and in alignment, without being prescriptive, and recognising that local nuances will mean INTs look different in each Place.
- **A commitment from each of our Places** to work ambitiously and intentionally, through a 'test and learn' approach, toward a shared vision for neighbourhood working.
- **Providing a way to build upon, not undo, existing integration successes** recognising that there has been significant progress in recent years and any re-structure takes capacity, time and energy. We do not want to overhaul what is working well, rather we want to develop an adaptable strengths-based way of working.

It is **not**…

- **Static**: this framework will evolve over the coming years as neighbourhood working builds across the SEL system and will be updated to integrate new and effective approaches that have been developed and tested, bringing in learning from previous integration efforts.
- **Exhaustive**: each Place and INT will need to work through local challenges and delivery questions to ensure their INTs work effectively within their local system and are tailored to the needs of their local populations.
- **About just the 'top of the pyramid':** this framework describes a whole system, whole-population approach which strives to improve the lives of all people of all ages across SEL.

Key ingredients

Drawing on learning from other INTs, as well as the conversations we have had to date with stakeholders, key commonalities across models and suggestions for effective neighbourhood working include:

- **Be organised around population health needs** and avoid unwarranted variation. This will involve using population health data to obtain a deep understanding of local communities and use this to proactively identify people who would benefit from support earlier.
- **Be a system-wide way of working and a model of care, and not a programme of discrete projects.** This will include joint workforce and estates planning to enable sharing of assets to best use system resources and promote integration.
- **Eliminate siloed working practices** through equal access to information and flexible models of working. Supporting frontline staff to work in an integrated way—where every connection counts—ensures that teams are equipped to collaborate seamlessly across boundaries. This approach minimises gaps in care and encourage cohesive service delivery, so residents are unaware of how they are being moved through the system to meet their needs.
- **Embed a robust interprofessional training infrastructure.** System leadership training should be a core component of the INT model, with health professionals trained together to strengthen collaboration, build cohesive teams, and foster interprofessional relationships. Training must include data analysis and interpretation to enable INTs to effectively use Population Health Management (PHM) tools for proactive decision-making. This will support succession planning and sustainable leadership within and beyond INTs
- **Have an overarching quality management system** – ideally linked with the quality improvement method – so teams can work in psychological safety, confident in what they are delivering and how they do works and be assured of the impact of the INT way of working.
- **Align to partner and system priorities** to ensure one direction of travel.
- **Shared, clear metrics** expected for INTs will help ensure local decisions are data-driven and ultimately achieve the expected outcomes, even if *what* they do is different to achieve these dependent on local populations and assets. Consistent processes for reviewing outcomes will ensure those which do not see progress over time are understood, addressed, and relevant learning is shared.
- **Release capacity which is reinvested to scale the model sustainably.** This will require routinely measuring impact to understand and embed what works and build a body of evidence.
- **Increase the proportion of resources used to support people to stay well for longer.** This will include offering joined up accessible preventative care, making full use of the knowledge and skills of the team, as well as ensuring the contractual mechanism and human resources (HR) infrastructure is in place to enable this. Commissioners /partners should be able to readily draw on this in relation to job planning/recruitment.
- **Be underpinned by interoperable digital tools and knowledge** that support population data analysis and enable person-based care.
- **Have robust leadership and shared governance arrangements** enabling services to be arranged at neighbourhood level to maximise their ability to engage with local communities and shift investment towards prevention. This includes effective clinical governance that allows genuinely shared care between organisations and professions that make up an INT.

We recognise there will be a level of local variation to ensure each neighbourhood can serve the local population needs. However, the broad approach to integrated neighbourhood working should remain consistent across all population groups and all areas within SEL.

Taking a population health approach

The success of INTs will rest on our ability to develop a deep understanding of our local populations. INTs will be organised around data insights drawn from **Population Health Management (PHM) analyses** - providing the evidence base to tailor services to local need and shift the dial to prevention.

To understand local needs, we will need to define a way to effectively **segmenting our population** (including those who are not registered in SEL general practices) and capturing key priority cohorts. Our segmentation model must:

- **Cohort across all life stages (children to older people) and need status (low- to high-)**, ensuring no one slips through the net
- **Reflect the different factors** that influence a person's needs (e.g., health conditions, psychosocial attributes, wider determinants)

PHM will be used to build up a richer picture of local populations over time, recognising that **data availability may be limited during the mobilisation of INTs** and **processes for continuous learning and adaptation to PHM insights** will ensure INTs remain responsive to changing population health needs.

The voice of residents will be a key input into PHM, essential for completing the picture implied by the data.

How do we get there?

- Agree a common language to describe our population segments to facilitate integrated planning and support collaborative working.
- Agree key metrics to enable a degree of comparability between Places.
- Invest in organisational development to implement new tools, and ensure staff have the ability to effectively use them and integrate insights into delivery and improvement.

A number of our Places in SEL and INTs elsewhere in London are adopting the **Bridges to Health** approach to segmentation. The approach can be tailored to different INT priorities (e.g., around CORE 20 plus 5 and to include social determinants of health). Examples of key areas identified using the Bridges to Health approach in SEL:

Healthy	Healthy at Risk	Single Illness	Lower Complexity	Higher Complexity	End of Life
	e.g. hypertension low frailty obesity	e.g. single LTC high utilisation mild mental illness	e.g. 2-3 LTCs severe mental illness disability	e.g. 4+ LTCs organ failure dementia high frailty	

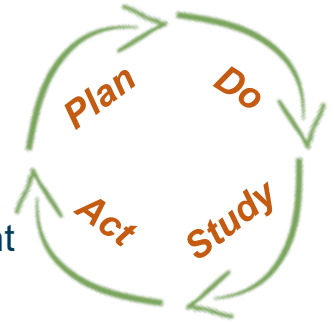
Adopting a test and learn approach

South East London Integrated Care System

We recognise that INTs are a radical change to existing ways of working and will therefore require experimentation through the early implementation phases to understand what is and is not working and explore ways of overcoming challenges.

Over time, our INTs across SEL will also evolve to respond to local population needs. This flexibility will be essential to address local inequalities and deliver services which are genuinely holistic and preventative.

To ensure INTs are delivering impact in the right places, we will adopt a "test and learn" approach to quality improvement which creates space for failure and ensures we understand our impact with each new iteration of the INT model, enabled by:



- **Quality Improvement (QI) metrics aligned to and embedded within the local and SEL-wide vision for INTs.** Metrics must develop our understanding of our impact in key INT priority areas including inequalities and prevention, recognising that preventative interventions demonstrate impact over the long-term, often in diffuse ways.
- **Being expansive and innovative when sourcing data and evidence,** drawing in and learning from ongoing QI insights, while making best use of existing evidence and information collected in the community, regionally, and nationally.
- **A culture of evidence gathering and rigorous and rapid evaluation** to inform future planning, design, and delivery. By building a robust evidence base, our INTs will be able to learn from each other, develop sustainably and target improvement efforts toward what we know works, and demonstrate impact which can secure funding into the future. Evidence gathering should be coordinated at system-level to coordinate efforts and ensure all Places benefit from key learning.
- **Ensuring a degree of comparability between QI metrics for our INTs and Places** so we can understand the drivers of impact across SEL, action system inequalities, and ensure every resident in SEL experiences good quality neighbourhood services.
- **Concise reporting requirements** which are focussed on impact and proportionate to the monitoring capacity of each INT partner.
- **A standard approach to applying PDSA-style (Plan, Do, Study, Act) improvement cycles between INTs**, and embedding learning, evaluation, and improvement.

Geography principles

Designing the geographical footprint for INTs needs to balance local population needs, existing healthcare boundaries, local assets, and operational efficiency. Key components for SEL to ensure boundaries enable effective INT functionality include:

Centre around populations and natural communities. While INTs are expected to naturally coalesce around registered populations linked to GP lists, it is crucial to address challenges such as PCNs engaging in multiple neighbourhoods where INT boundaries do not align and recognise that SEL maintains responsibility for those not registered but living in SEL too. This requires clear differentiation between integrated neighbourhood working and INTs, ensuring alignment without disrupting care continuity.

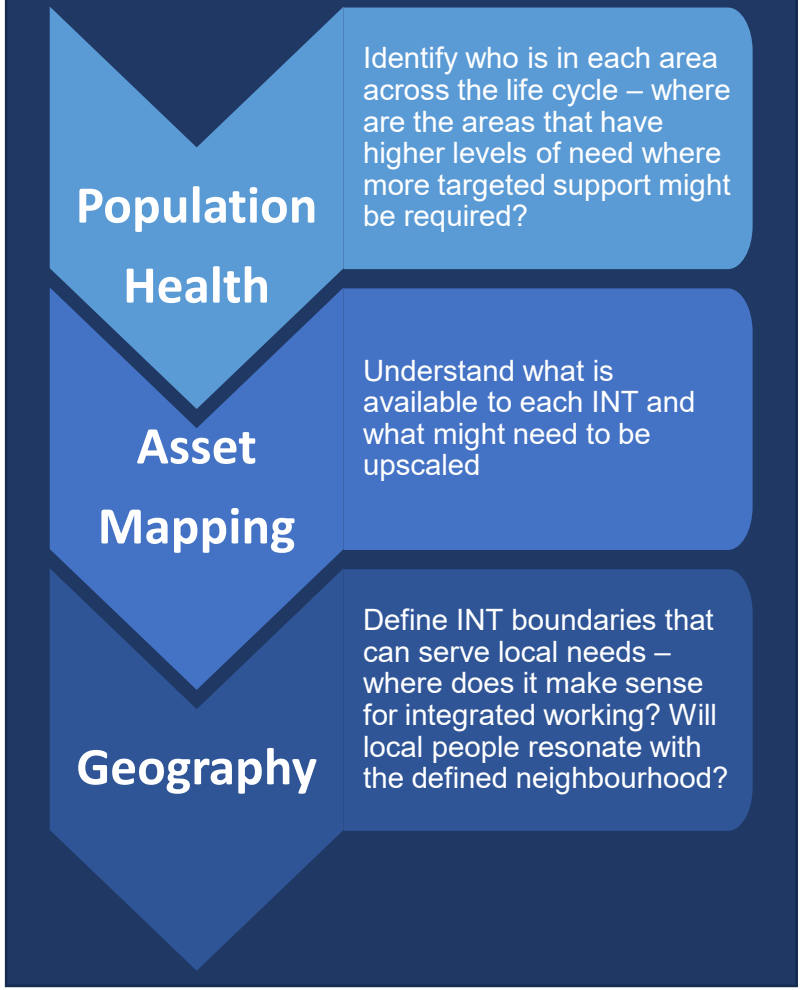
Build on existing networks and local assets. Enhancing integration without requiring new infrastructure where possible is essential to ensure equitable service delivery while maximising existing resources. This will require better use of primary care estates (e.g., community pharmacy consultation rooms) and addressing challenges in engaging community pharmacies with PCNs (particularly those arising from PCN contractual frameworks).

Include population sizes roughly between 50k-100k. Where the population size exceeds 100k, there needs to be consideration of the additional resource required for this area to ensure the size is 'manageable'.

Enable not hinder joint working. The number of INTs must be of a minimum viable scale for team co-ordination; able to be effectively in-reached to by borough-wide services and have appropriate travel times for staff to patients' homes and residents to services.

Adapt footprints based on specific challenges. Areas where there are higher levels of deprivation or inequality require additional, smaller INTs – or at least 'mini-hubs'– for targeted support while larger geographical area could allow for fewer but geographically broader INTs focused on e.g., long-term conditions and frailty. INTs should still pro-actively maintain a degree of demographic and needs variation within INT footprints.

All Places have broadly followed a three-step process to model INTs:



Where there needs to be consistency

Taking a strengths-based approach means there will be local differences. But, beyond working to the same objectives regarding improving health outcomes and addressing inequalities, SEL would expect all to have:

Access to core services: INTs should enable increased service access, and ensure residents have equitable access to essential health and care services within the 'consistent functions' of the INT model (see slide 5) regardless of where they live, proactively identifying and acting on access inequalities.

Proactive care for those with both rising risk and high risk of acute intervention and prevention, beginning with 3+ LTCs, moving along the frailty continuum. This supports overall better outcomes, improved sustainability, and a population well enough to improve access/ address inequalities (e.g., by spotting if there are patterns in service access issues at a level where it can be addressed).

Access to and use of population data: an enabler to the above, population health management (PMH) analysis will drive the composition and priorities of INTs. Each INT will need to identify their baseline position to measure change in outcomes and ability to re-identify patients, as well as a consistent approach and sufficient capabilities to interpret and draw insight from population data.

Data sharing and digital platforms: there needs to be a concentrated effort to ensure INTs are underpinned by interoperable systems and common digital infrastructure to enable co-ordinated care.

Governance and accountability: consistent governance structures across INTs will support clarity in roles, decision-making and accountability. There will need to be clear reporting mechanisms, such as the existing ICB Executive Groups and Local Care Partnerships, and standardised metrics* to report against to share learning, establish effective two-way communication channels, and iterate priorities.

A test and learn approach: recognising that neighbourhood working will take time and will require iteration. INTs should adopt a consistent approach to applying PDSA improvement cycles and embedding learning, evaluation, and improvement.

Coproduction and engagement with communities: communities should experience, understand, and have the opportunity to input into INTs in the same way no matter which INT their locality is served by. Messaging to the public should be consistent to prevent confusion and support proactive engagement and uptake of services.

Common interface with larger / cross-Place providers: e.g., with acute trusts. This will help avoid providers managing an impractical number of different systems.

**Note different Places will want to maintain or develop some specific outcomes measures which speak to major issues on their own patch too.*

Where there will be local variation

Fundamental to our INT model is the need to balance consistency with local variation and taking a strengths-based approach. This means that INTs can effectively meet the differences in local population needs. Emerging thoughts on where there will need to be local variation in INT models include:

Partnering with the voluntary sector: each neighbourhood will have its unique network of voluntary and community sector organisations; leveraging local strengths can amplify the impact of INTs. Consistency in the manner of partnering and engagement, however, should be upheld through common partnering principles.

Interfaces with local authorities: local authorities will have different structures feeding into INT delivery - INTs will need to variously respond and integrate with these to ensure local authority voices are centred in delivery.

Composition of specialist input and resources feeding into each INT: while the core INT will remain consistent from INT to INT, based on local population needs, specialist services should be positioned to flexibly respond to changes in local demand and ensure staff operate on the right spatial level with respect to capacity and demand. Where there is more limited workforce capacity or services, these resources may need to be shared across INTs.

Community engagement: a critical element of the INT model will involve co-designing services with communities and residents to ensure solutions are shaped by lived experiences and local priorities. Tailored public engagement strategies in particularly diverse areas will ensure that INTs meet the needs of all their residents, especially those historically underserved.

Local health system economics: INT priorities will be informed by and respond to local variance in demand for services and supply– for instance, where there may be high, avoidable utilisation of high-cost placements such as residential care.

Physical infrastructure: like workforce, effective INTs should be built on what is already working well within communities which will necessarily look different in each neighbourhood depending on how residents want to and can engage with health and care and wider public services. This might mean developing integration hubs that e.g., leverage hospitals as in Bexley, build on existing community hubs or form ‘mini-hubs’ as in Lewisham.

Key areas of work to deliver Neighbourhoods

South East London Integrated Care System

SEL recognises INTs require a big shift in ways of working, and some requirements will take time to fully implement. However, this should not prevent Places from progressing INT implementation. The following describes key areas of work that will be included in the INT implementation plans at Place and SEL levels, that will need to be driven from a local level upwards with support from SEL to ensure that INTs meet local population needs.

Delivery of INTs	Enabling functions delivered once across SEL, building from Place upwards	Enabling functions delivered at Place and across SEL concurrently
• Confirm neighbourhood footprints and align service delivery • Establish Integrated Neighbourhood Teams (INT) • Implement 3+ LTC scheme* • Implement Frailty scheme* • Implement CYP scheme* • Agree and implement integrator function • Utilisation of population health management (PHM) to address health inequalities through neighbourhood working	• Single PHM function for the ICS • Ongoing evaluation of impact • Outcomes framework, using shared metrics • Digital enablement of neighbourhood working including single health and care record	• Flexible workforce models and associated culture change • Comms and engagement • Delivery and implementation of a common QI process to support test and learn approach • Agree governance to understand implications and secure good governance of neighbourhoods • Identify and implement neighbourhood hubs, linking to broader estates planning and community diagnostic centres (CDC) development • Create business cases, linked to SEL sustainability

*To common spec collaboratively developed by the 6 Places and with support from SEL.

South East London
Integrated Care System

Where we are now

Overview of where Places are

All six Places have made significant efforts and are focusing on developing their neighbourhoods, and all have best practice examples of integrated working at a neighbourhood level. The challenge will be to move from a set of projects to an embedded, systemic shift in the way of working to provide a tangible impact on patient outcomes, moving towards a preventative more integrated approach.

How do INT models align with the SEL Framework?

The development of INT models across all Places broadly align with the tiered system outlined in the SEL Framework (page 5). All INTs will be centred on neighbourhood-based care, with consistent principles such as population health management, proactive prevention, and integration across health, social care, and voluntary sectors. Collaboration with local authorities, PCNs, and the VCSE sector has been recognised as critical across all Places, ensuring models are tailored to local needs while maintaining alignment with system-wide priorities. There is an emphasis on resident-centred approaches, using population health data to identify and address inequalities.

What will neighbourhood governance look like?

- The strategic direction and associated outcomes for INTs are to be determined by the ICB and Local Care Partnerships, while the INTs will be responsible for their delivery.
- Our INT governance structure at a SEL-level for INTs is in development, but will encourage collaboration and shared accountability across organisations and sectors whilst reducing silos. It will leverage the existing Neighbourhood Based Care Board, Primary Care+ Group and Local Care Partnership Boards to help support working across organisational boundaries, resolving interface issues and balancing autonomy with consistency.
- Many Places have started to or already agreed governance and oversight arrangements for INT design and implementation; with many structured through a neighbourhood strategic leadership function with cross-system membership, reporting to Place-level governance, and with reports including INT and programme-specific working groups.
- Places have sought to align governance arrangements with existing neighbourhood-based programmes (e.g. CHILDs).

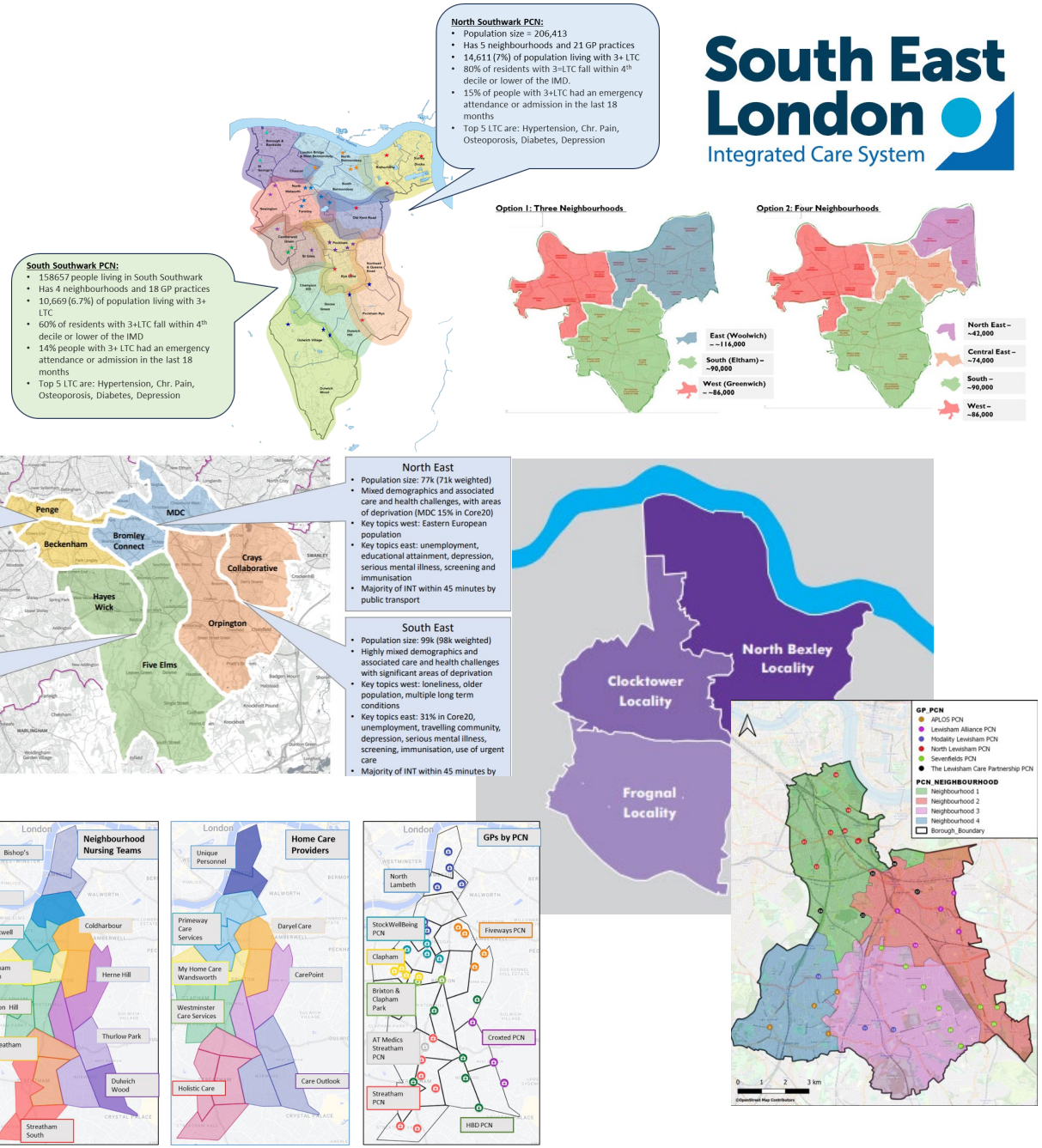
Overview of where Places are

All Places are at the point of reaching consensus on neighbourhood footprints (4 Places have confirmed; 2 are at final stages). It is likely we will have c.27 neighbourhoods across SEL:

- Bexley: 3 Neighbourhoods
- Bromley: 4 Neighbourhoods
- Lewisham: 4 Neighbourhoods
- Lambeth: 8 Neighbourhoods
- Greenwich: TBC – likely 3 or 4 Neighbourhoods
- Southwark: TBC – likely 4 or 5 Neighbourhoods

Neighbourhoods in each Place will adhere to SEL's geography principles (p.13). It is anticipated that some PCNs will have to work across neighbourhood boundaries to provide wrap-around support to all residents.

SEL Places have started to identify potential sites for integration to support INTs as their physical place for collaboration. As part of taking an asset-based approach, these sites already have some level of multi-disciplinary working and integrated services being delivered and will be different in each Place.



INT initial areas of focus

South East London Integrated Care System

- **As part of SEL's 'test and learn' approach, there will need to be a level of consistency across INTs** in terms of what they focus on to be able to compare success measures and demonstrate the impact of this new way of working, ensure the work aligns with SEL's strategic priorities and enable shared learning across Places about what is working and not working to facilitate continuous improvement.
- **SEL has initially identified three population groups for INTs to focus on** where the opportunity for improvement is greatest, including addressing health inequalities and improving health and care outcomes for our population. This will also enable a genuine and sustainable shift in investment across the system.

1. **3+ Long-Term Conditions**
   There are currently pilots in each place, and there is a current cost of £18m, £16 Non-Elective (NEL) admissions per year, £3-6m outpatient opportunities for diabetes alone.

2. **Frailty and those approaching end of life**
   There are examples of best practice already and a current cost of £244m* per year on NEL admissions. This also aligns with how many Places are prioritising Ageing well as a strategic goal over the next six years. This might mean pivoting virtual wards and other admission avoidance initiatives into maximising independence outside of the hospital.

3. **Children and Complex Needs**
   There is an existing model which has demonstrated reductions in GP and outpatient appointments, Accident and Emergency (A&E) attendances and NEL admissions.

- Initial INT rollouts and pilots within each Place will focus on these areas. However, there is an expectation that as INTs develop, they may identify additional specific priorities based on their local population needs.

Key assets and challenges within Places

The following details examples of existing assets that Places are building upon, as well as key challenges that have been identified that Places will look to address as they implement their INTs.

EXAMPLES OF EXISTING ASSETS

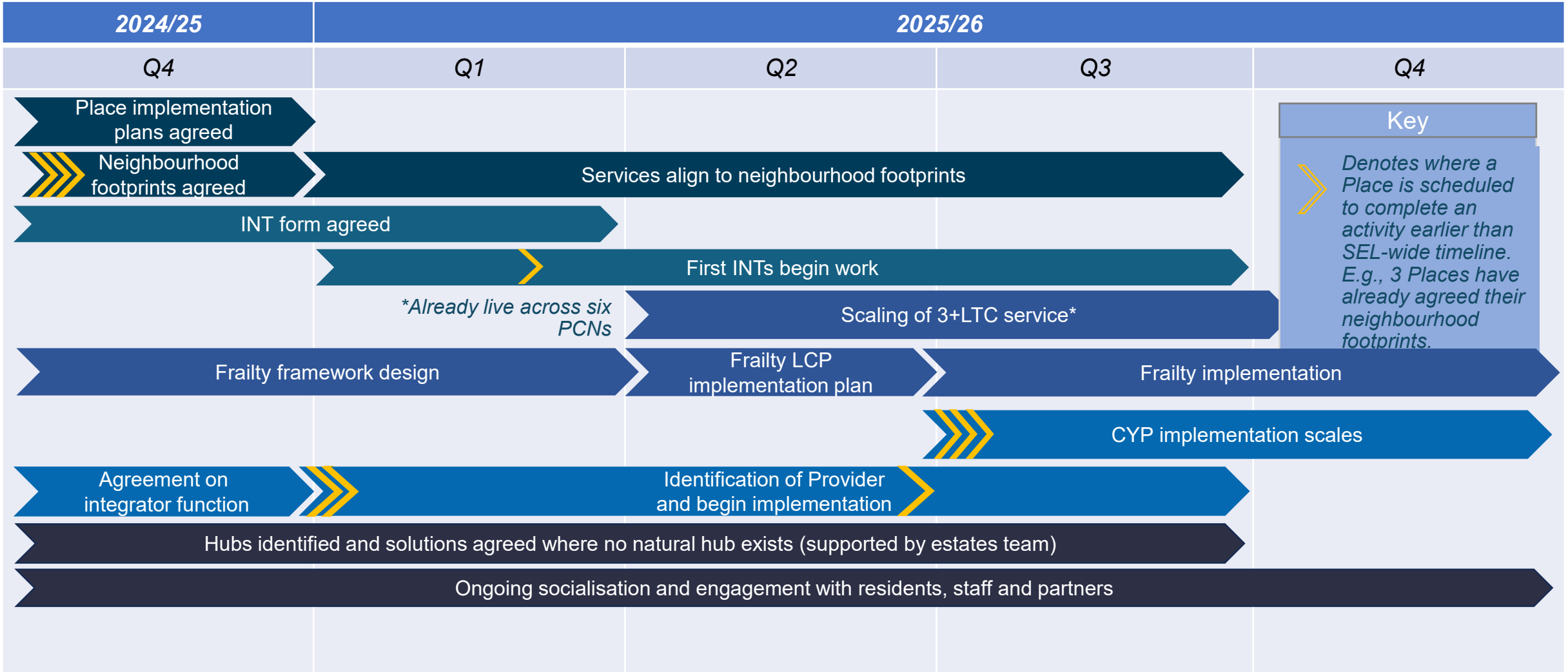
1. **Established PCNs:** In many places, PCNs form the foundation of neighbourhood-based care, providing a structure for GP practices and associated services to work collaboratively within INTs.
2. **Local authority partnerships:** Strong partnerships with local councils are facilitating better integration of health and social care, particularly through joint governance structures and co-designed programmes like housing and benefits support. Local authorities are also providing critical infrastructure for neighbourhood hubs.
3. **Existing community hubs and networks:** Community hubs and voluntary sector organisations have well-established relationships with residents and are being leveraged to provide hyper-local, resident-focused care. Many Places have already trialled co-location of services, which has improved access and coordination in some areas.
4. **Population Health Management (PHM) Tools:** All Places are beginning to use PHM data to proactively identify health needs and target interventions, particularly for underserved populations and those at higher risk (e.g., long-term conditions and frailty).
5. **Proactive approaches to preventative care:** Initiatives such as social connection programmes, support for carers, and community-based activities are being trialled across SEL, building on existing voluntary sector strengths.
6. **Workforce and leadership development:** There is a focus on multidisciplinary training, fostering stronger collaboration across sectors, and building the leadership capacity needed to drive system-wide change.
7. **Digital integration and interoperability:** Progress is being made on shared care records and data-sharing agreements, which are helping to reduce silos and improve coordination.

EXAMPLES OF KEY CHALLENGES

1. **Geographic and boundary misalignment:** Misaligned PCN and neighbourhood footprints create complexity in planning, cross-boundary coordination, and service delivery for INTs.
2. **Data sharing and interoperability:** Barriers to data sharing between health, social care, and voluntary sectors hinder real-time decision-making and seamless, person-centred care.
3. **Governance and accountability:** Current governance arrangements vary at Place level around INT implementation and alignment with broader system priorities.
4. **Workforce and voluntary sector capacity:** Workforce shortages, cultural change requirements, and reliance on under-resourced voluntary organisations challenge the ability to scale and sustain INTs.
5. **Infrastructure and resource allocation:** Disparities in access to suitable community spaces and inequitable resource distribution hinder efforts to meet the needs of underserved areas.
6. **Cultural and operational alignment:** Aligning organisational cultures and shifting from reactive to proactive, preventative care requires time, effort, and significant mindset change.
7. **Sustainability and resident engagement:** Embedding pilot successes into sustainable models and involving residents in co-design remains inconsistent across SEL, limiting long-term impact.

Next steps: testing, learning and scaling

Each Place is making significant progress towards establishing and embedding their respective INT models. The following timeline sets out when all Places will have delivered an area of work, reflecting the different starting points and assets in each Place.



South East London Integrated Care System

NHS South East London

Roadmap

Initial neighbourhood implementation approach

Each SEL Place is in a different stage of developing their approach to integrated neighbourhood working. The following represents a starter for ten based on initial conversations for the decisions and activities that need to be co-developed with partners and residents locally to ensure neighbourhoods and services delivered are built around and address population needs.

Where we are now

Phase 1
Scope & design

- ✓ **Have a clear shared vision, purpose and high-level outcomes** aligned to SEL vision
- ✓ **Expand scope of what we mean by primary care** to inform development, thinking beyond health to include e.g., social determinants, urban planning, non-health-specific community services
- ✓ **Pull together data** from across health, public health and social care to achieve a clear view on: existing neighbourhood footprints, community assets and population needs, including inequalities
- ✓ **Agree common language** describing our population segments to facilitate integrated planning and working
- ✓ **Define geographies** for neighbourhood footprints, including how PCNs align with neighbourhood teams
- ✓ **Identify initial priority cohorts** for INTs
- ✓ **Align plans with existing** integrated neighbourhood working iniatives (e.g., existing work across PCNs)

Phase 2
Refine design and set up

- ✓ **Identify and agree workforce, skills and resource requirements** of INTs to meet population needs
- ✓ **Assess whether the right resources are in the right place** for integrated delivery. If things need to change, work out how – with population input
- ✓ **Collectively allocate resources** based on identified need, exploring novel arrangements (e.g., contracts, incentives) removing historical integration barriers
- ✓ **Develop population health management** approach to enable proactive identification and management of residents
- ✓ **Establish governance** to ensure clear leadership and accountability, including risk management and clinical governance
- ✓ **Design and agree how INTs will perform integrator functions**
- ✓ **Agree measures of success** and monitoring approach for initial implementation

Phase 3
Test and learn

- ✓ **Develop integrated multi-organisational neighbourhood teams** for a chosen population cohort in an agreed geographic footprint
- ✓ **Embed digital tools and knowledge** that enable a shared, population-health driven approach
- ✓ **Facilitate cross-sector relationships and deploy collective resources** to support workforce, digital solutions, estate utilisation and wider infrastructure
- ✓ **Share learning, capacity and resource across neighbourhoods**, converging around best practice
- ✓ **Use established governance** to continously assess learning, progress and impact and integrate into the development of the full INT implementation
- ✓ **Based on learning, start shifting resources** to enable expanded population coverage and increase resource proportion supporting prevention

Underpinned by…

Ongoing engagement and meaningful participation

with partners and residents to enable cultural change and INTs being built and flexed around residents needs, making full use of the knowledge and skills of the team across organisations and ensuring learning and experience is maximised and shared to continuously improve.

ENCLOSURE: 5
AGENDA ITEM: 7

ONE BROMLEY
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One Bromley Local Care Partnership Board

DATE: Thursday 27 March 2025

Title	**One Bromley End of Year Achievements 2024-25**	
This paper is for **information.**		
Executive Summary	This presentation highlights some of the many achievements and improvements that have been made across Bromley services over the last year. It focuses on areas which we haven't reported on in detail previously and which are making a difference to service provision, experiences and outcomes.	
Recommended action for the Committee	To note	
Potential Conflicts of Interest	None	
Impacts of this proposal	Key risks & mitigations	N/A
	Equality impact	The presentation shares information on schemes aimed at reducing health inequalities.
	Financial impact	N/A
Wider support for this proposal	Public Engagement	Many of the improvements undertaken across Bromley are informed and shaped by people's views and experiences of care.
	Other Committee Discussion/ Internal Engagement	One Bromley Executive and Bromley Senior Management Team meetings.
Author:	Helen Marsh, Head of Communications and Engagement, NHS South East London ICB	
Clinical lead:	Dr Andrew Parson	
Executive sponsor:	Dr Angela Bhan, Bromley Place Executive Director, NHS South East London	

ONE BROMLEY

WORKING TOGETHER TO IMPROVE HEALTH AND CARE

Our Year 2024/25

Working together to improve the health and wellbeing of Bromley people and communities

Introduction

Our progress and challenges

The One Bromley local care partnership has gone from strength to strength over the last year, with more care safely delivered outside of hospital, new neighbourhood integrated services, and improved outcomes for Bromley people and communities.

The priorities and programmes aim to empower people to take better care of their own health, improve performance and outcomes, reduce hospital stays and enable more people to be cared for at home or in community settings. We made significant progress during 2024/25, and several of our initiatives were recognised at national awards.

Challenges remain, not least the Synnovis attack which had, and in some cases is still having, a significant impact on services across the system. However, we continue to focus on working collaboratively to deliver proactive and personalised integrated care to meet needs, help reduce inequalities and provide the right care in the right place.

We have now completed two years of the One Bromley 5 Year Strategy which sets out our ambition to improve the wellness of Bromley people and communities. The aim is to achieve this by prioritising prevention, focusing on people living with long term conditions, those at risk of emergency admission to hospital, frailty and reducing health inequalities. Examples of progress across each area enclosed.

The three key priority areas shaping future work remain unchanged:

- Improving population health and wellbeing through prevention and personalised care.
- High quality care closer to home delivered through neighbourhood services.
- Good access to urgent and unscheduled care and support.

Implementing neighbourhood working

Defining our neighbourhood focus

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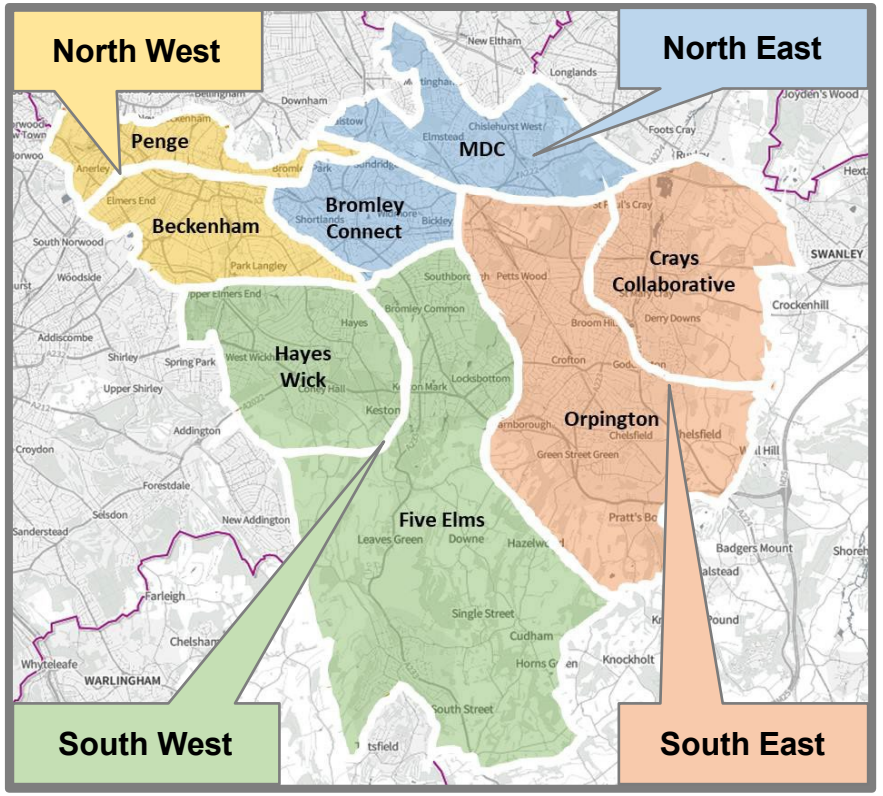
Agreeing footprints and priorities

INITIATIVE: Integrated neighbourhood teams (INTs) are a key part of our approach to neighbourhood working in Bromley.

ACTIVITY

- One Bromley partners have agreed four geographic footprints for INTs in Bromley. Our INTs each comprise two full primary care networks, have good transport links and population variation across the neighbourhood.
- Workshops with senior leaders in the Local Care Partnership have also focused on ensuring we have a clear narrative for our staff and residents as to 'why' we are developing INTs and what, initially, they will focus on in Bromley.
- We are using the real problems faced by our patients and organisations as the driver for our INT work: focusing where coming together in a multi-agency and multi-disciplinary way delivers better outcomes for the same or reduced financial cost to the Bromley pound.
- Through this we are fostering a shared understanding of what neighbourhood working means in Bromley as the foundation for our work in 2025/26.



Starting our neighbourhood journey

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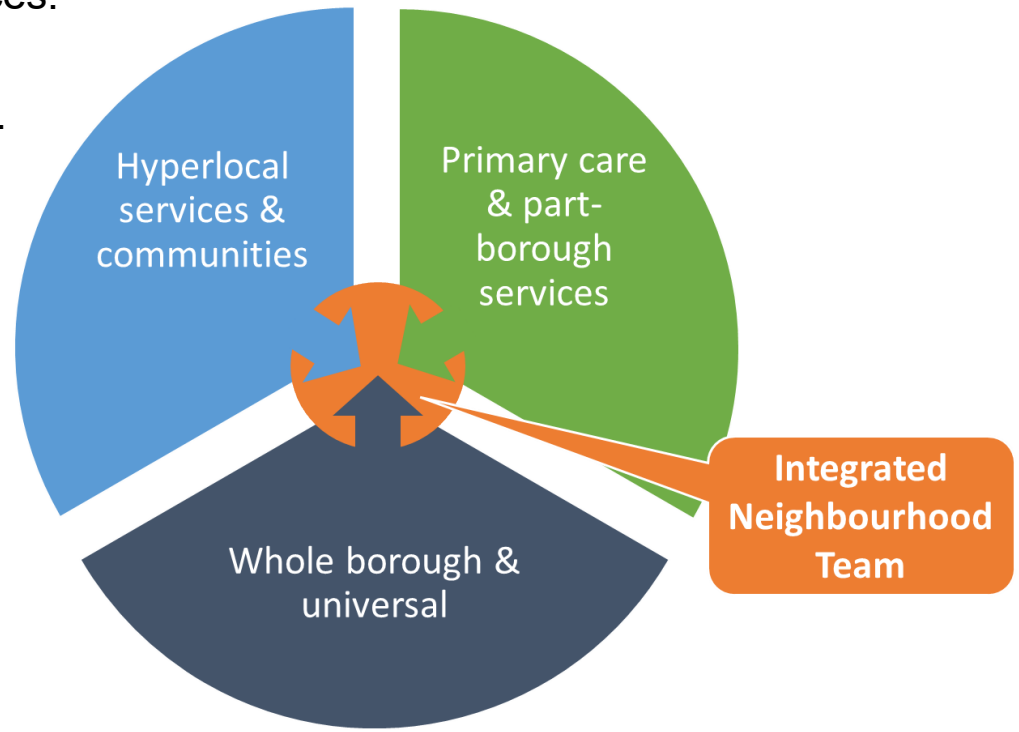
Defining our shared vision and committing to new ways of working

INITIAL FOCUS AREAS

- We recognise INTs are about delivering more relational, co-ordinated and prevention focused ways of working across our organisations, for and with the local communities of Bromley. We are starting with:
- **Adult** – people living with frailty, three or more long term conditions or being discharged from hospital into the care of community health and care services.
- **CYP** – moving beyond our Bromley Children's Health Improvement Partnership's initial focus on general paediatric referrals to secondary care.



MOVING FORWARD

- We are now building our INTs with staff and our communities, using our existing multi-disciplinary and multi-agency working in adults and children and young people as a firm foundation.
- We are utilising a Delphi methodology in which all stakeholders contribute. This is used to develop the service model, clinical governance, standard operating procedures, contracting, finance, wider governance plans for INTs.
- Looking to South East London, regional and national developments to ensure Bromley benefits from innovative thinking, support and mechanisms to deliver this innovation.

Integrated community care for children and young people

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Delivering more care closer to home

<u>INITIATIVE:</u> developing the multi-agency approach to developing and implementing children's triages and clinics across the borough.

BCHIP
BROMLEY CHILD HEALTH INTEGRATED PARTNERSHIP

ACTIVITY

- The Bromley Children's Health Integrated Partnership (BCHIP) expanded across the borough, with all eight PCNs onboarded and delivering the pathway.
- Close to 2,000 children have now been referred since the new pathway began, of all children and young people being triaged approximately 25% then moved onto the multi-agency community clinic.
- In 2025/6 the focus will be to use the learning from BCHIP to extend the offer in line with our development of the children and young people's Integrated Neighbourhood Teams.
- In addition, we will work with colleagues across the initial BCHIP pathway to review, refine and embed practise to ensure all partners feel the requisite benefit from the new way of working.

IMPACT

- The impact of the service has been significant, with patients receiving services up to 33 weeks faster through BCHIP.
- Children attending triage have 21% reduced attendances at primary care for the following six months, and those attending a clinic have a reduced attendance by an average of 61%.
- The rate of referrals into the general paediatric pathways also reduced, with all activity now being held within BCHIP.
- Patient and professional surveys have provided overwhelmingly positive feedback, proving what can be achieved when services are designed and delivered locally, "I didn't have to go miles and could park nearby which is essential when with a baby".

Supporting older residents

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Enhanced health in care homes (EHCH)

INITIATIVE: Working with Bromley care homes and One Bromley partners to deliver more personalised proactive care closer to home for our residents.

ACTIVITY

- Care homes supported to improve their digital maturity, achieving the highest levels in South East London and exceeding target.
- Since September 2024, 44 more care home staff have received RESTORE2 training to enable them to better identify and respond to deterioration.
- Care homes supported to use the Universal Care Plan (UCP) system to view, edit and create digital personalised plans. 22 out of 31 South East London homes onboarded were Bromley homes. 61% Older Peoples care home residents have an active UCP.
- In February 2025, care homes and local health service providers engaged in an event to coproduce the Enhanced Health in Care Homes workplan for 25/26-26/27.
- A multi-agency Action:Falls campaign launched in March 2025 with a framework focusing on prevention and streamlined management of falls.

IMPACT:

- Care homes are recording and sharing residents' information more securely and effectively: 100% compliance for 23/24 Data Security Protection Toolkit (DSPT), 90% using NHSmail, 78% using proxy access, and 90% using Digital Social Care Records.
- Staff confidence in recognising and escalating deterioration has improved: "*Getting me to think outside of the box of just giving personal care – I can now spot a deteriorating resident and escalate for them to get quicker treatment.*"
- UCPs are enabling more personalised and coordinated care for residents. The preferred place of death was achieved for 71% of care home residents, which is higher than the general population.
- The falls framework provides clear guidance to care home staff and healthcare professionals to reduce unnecessary hospital attendances and admissions and improve the resident's experience post-fall.

Supporting older residents

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A focus on frailty

INITIATIVE: working towards greater consistency in the frailty space and a proactive focus on prevention.

ACTIVITY

- Introduced the Anticipatory Care Team (ACT), which uses proactive case finding through EMIS population reporting to identify housebound patients with unmet needs. Patients then receive a holistic assessment either home or in clinic.
- Two new frailty and older people clinical and professional leads were recruited, and the frailty strategy refreshed.
- Piloted a multi-disciplinary, multi-organisational review process for care and nursing home residents most at risk of admission to hospital.
- Several stakeholder events have been held which have informed our immediate priority areas:
    - Use of consistent frailty recognition tools to drive pathway decisions and patient conversations.
    - Roll out of standardised frailty competency training to upskill the workforce.
    - Sharing consistent health messaging to help drive the preventative agenda.

IMPACT

- Individuals continue to be assessed in the acute frailty unit before discharge home with a care plan or transferred to the relevant medical service for further treatment.
- Evaluation in September 2024 showed 548 initial patient assessments completed and 908 follow-up contacts. Work to monitor the assessment-to-intervention rate continues.
- The case management pilot has expanded to four Primary Care Networks (PCNs) in Bromley to support complex patients who need additional care for a short time following a multi-disciplinary team meeting.
- Phase 1 data shows a 41% improvement in the Rockwood Frailty Score, a 52% reduction in GP contacts, and an 83% improvement in overall wellbeing scores.
- An increase in patient universal care plans for care and nursing home residents which are used by the London Ambulance service and others to ensure appropriate care and treatment for some of the most vulnerable patients.

Reducing health inequalities

Reducing health inequalities

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Ensuring all residents have access to the support they need

<u>INITIATIVE:</u> the launch of the One Bromley Wellbeing Hub, a one stop shop for care, advice and support in an accessible location.

ACTIVITY

- The One Bromley Wellbeing Hub opened June 2024, with a formal launch by the Mayor of Bromley on 9 July 2024.
- The Wellbeing Hub hosts several regular services including Vital 5 Checks, Bromley Well and Citizen's Advice, the Stop Smoking Service, maternity vaccinations and maternity stop smoking support, sickle cell community care.
- In addition, there are public health campaigns and ad hoc clinics for the school age and at-risk cohorts for Covid vaccinations.
- A key objective of the Hub is bringing together health, care, and voluntary services to work in a joined-up way for local people. Networking events are being held to facilitate collaboration and integration between providers in the Hub.

IMPACT

- Helped to reduce health inequalities and empower local people to live healthier lifestyles by:
  - Detecting Vital 5 risks and signposting and referring where appropriate to other services, 347 checks have been completed so far.
  - Bringing together health, care, and voluntary services to work together in a joined-up way for local people.
  - Bromley Well Advice services supported 156 residents in the first six months of operation.

Reducing health inequalities

ONE BROMLEY
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Offering better care for homeless residents in Bromley

INITIATIVE: working collaboratively to offer comprehensive health support for homeless residents.

HOMELESS HEALTH PROJECT

- The multiple award-winning Bromley Homeless Health Project is co-located with Bromley Homeless Shelter and is led by an Advanced Nurse Practitioner working five days a week, together with a Care Coordinator.
- The team carry out health assessments and provide treatment and referrals for single homeless individuals, who often have complex physical and mental health needs.
- Strong partnerships have been formed with the urgent treatment centre, emergency department and rough sleepers adult mental health project team to improve care and individuals are also supported to register with a GP.
- Links have also been made with an optometry provider which has run two sessions at the Homeless Shelter in the last year. Plans are underway to add an oral health promotion and clinical dental service for the homeless.

IMPACT

- 336 homeless people have been seen in the clinic in last 11 months.
- 135 referrals were completed to mental health, secondary care, physiotherapy, the drug and alcohol service and safeguarding.
- 20 seasonal flu vaccinations were administered.

Reducing health inequalities

ONE BROMLEY
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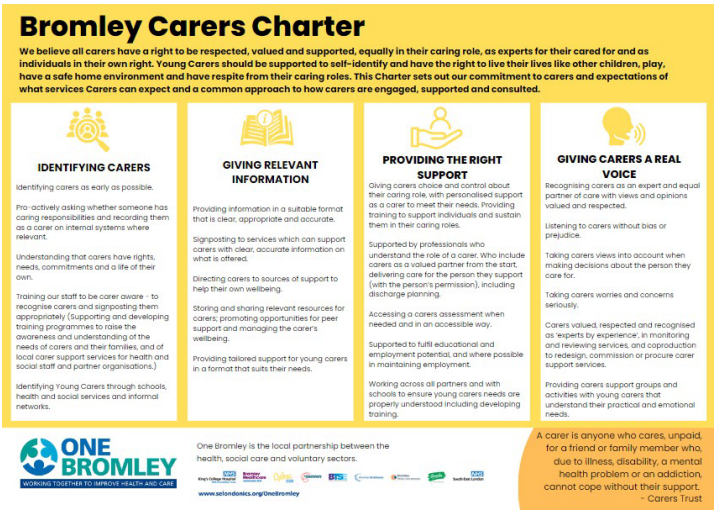
Creating a Carers Charter for Bromley

INITIATIVE: working in partnership to ensure all carers in the borough feel respected, valued and supported in their caring roles, as experts for their cared for, and as individuals.

ACTIVITY

- The One Bromley Carers Charter was launched during Carers Week in June 2024 and supported by an action plan of promotion, staff training, identification and information for carers.
- It was the result of a joint effort between Bromley Well, London Borough of Bromley, South East London Integrated Care Board and other NHS partners, who committed to a common approach to how carers are engaged, supported and consulted.
- Hard copies of the charter were distributed to GP practices, various locations at the Princess Royal University Hospital, Bromley Healthcare sites, social services sites, and Bromley Well partner charities, alongside exposure in relevant bulletins, newsletters and across social media.



IMPACT

- Borough-wide commitment to ensuring carers are seen, heard and respected.
- Carers are now being identified proactively and as early as possible.
- Improved signposting to services and clearer, more appropriate information shared.
- Carers offered more personalised support and more opportunity to share their views.

Reducing health inequalities at PCN level

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Improving health outcomes for patients with learning disabilities

INITIATIVE: the recruitment of Learning Disability Champions in each Primary Care Network to work with practices to improve the take up of Learning Disability Annual Health Checks.

ACTIVITY

- Primary Care Network (PCN) Learning Disability Champions worked to ensure member practices booked in a consistent number of health checks throughout the year and delivered a high quality of health checks.
- Regular contact with Learning Disability patients to book appointments and give reminders, taking the time to offer reassurance and arrange reasonable adjustments where appropriate.
- Working with Oxleas for support with contacting Learning Disability patients who have become uncontactable.
- Engagement with the Bromley Learning Disability Clinical Lead via monthly peer support meetings to facilitate shared learning and share Learning Disability Annual Health Check data to identify potential issues.

IMPACT:

- Annual health checks help to reduce morbidity and preventable deaths, improve health and wellbeing and improve quality of care.
- Reduced avoidable admissions to inpatient settings.
- Reduced workload on practice staff.
- 2024/25 saw the highest ever number of Learning Disability Annual Health Checks completed in Bromley.
- Most PCNs achieved the upper target for Impact and Investment Fund payment for Learning Disability health checks.
- The successful development of a team of Learning Disability specialists across Bromley to enable future expansion of support across encouraging vaccinations, screenings and weight management referrals.

Prevention in Primary Care

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Improving hypertension with self-management

INITIATIVE: introducing remote monitoring for blood pressure, designed to improve blood pressure control for at-risk patients through patient self-monitoring, supported self-management of hypertension and education.

ACTIVITY

- Launched the BP@Home service with the aim of improving the percentage of patients within target blood pressure.
- Patients were invited to take part and measure their blood pressure at home using a blood pressure monitor.
- They then upload readings to a digital platform at their convenience, to be reviewed at the GP surgery. If blood pressure readings are above a personalised target, the patient is invited to a clinical review.
- All Bromley Primary Care Networks are now operating a BP@Home service and have begun to embed this model as 'business as usual', thus providing the patients with an alternative option for blood pressure management that is convenient for them.

IMPACT

- Early indications are that this service has enabled patients to monitor and better self-manage their blood pressure remotely, thereby reducing the need for routine GP appointments.
- Initial data indicates that clinical management for patients enrolled in the BP@Home project are improving:
  - 80.8% have improved blood pressure since taking part
  - 55.4% have achieved their personalised target blood pressure
- Patient feedback also found they felt more empowered and better supported in their self-management.

Supporting access to Primary Care

ONE BROMLEY
WORKING TOGETHER TO IMPROVE HEALTH AND CARE

Building digital inclusion across the borough

<u>INITIATIVE:</u> working with Primary Care Networks to support residents with lower engagement in digital tools such as the NHS App and online consultations.

ACTIVITY

- A partnership focus on reducing disparities in digital literacy amongst older people, those with disabilities and those from areas of high deprivation.
- Interventions included patient events, drop-in workshops, staff training, printed educational resources, and a dedicated telephone line for patient queries.
- Several PCNs ran digital hubs to build patient confidence, improve digital literacy, and provide hands-on support.
- PCNs also partnered with Clear Community Web, and the Good Things Foundation, to hold joint information events with Bromley Libraries to expand community engagement and encourage digital access.

IMPACT

- NHS App uptake in Bromley increased from 64% in April 2024 to 67% by October 2024.
- Patient logins rose by nearly 110,000 over the same period.
- Patients reported greater confidence in using digital tools, and targeted interventions helped under-represented groups access GP services digitally, supporting improved access to healthcare services.
- Bromley's work on digital inclusion was shared as best practice across London primary care.

Supporting residents to live well

Managing winter

Keeping residents well and out of hospital

<u>INITIATIVE:</u> working collaboratively with One Bromley partners to manage winter demands, keeping residents well and out of hospital and ensuring services are available when they need them.

ACTIVITY

- Robust planning, additional capacity, out of hospital services, clear escalation processes and the underpinning support of the responsive discharge system all helped to manage the additional pressures.
- Events were held for GPs and other community staff to encourage uptake of community based urgent and emergency care pathways and services, and new arrangements enabled direct GP referrals to a range of services that help avoid hospital admissions.
- Information on what to do when you are unwell and a detailed Children's Winter Health Guide were published and widely circulated online and across community spaces.
- Advertisements were placed in local publications to support the campaign, and detailed winter health information featured on a local podcast.

IMPACT

- Despite a much higher flu season than last year the number of Urgent Treatment Centre attendances Oct-Feb remained stable.
- Winter Illness Hubs, provided in partnership with Bromley GP Alliance, offered 10,000 additional GP appointments during the winter months.
- Increased home-based rehabilitation capacity by 33%.
- Increased Virtual Ward capacity by 25% reducing the need for hospital stay for these residents.
- Increased GP e-consults, with almost twice as many completed in December 2024 as December 2023.

Winter vaccinations

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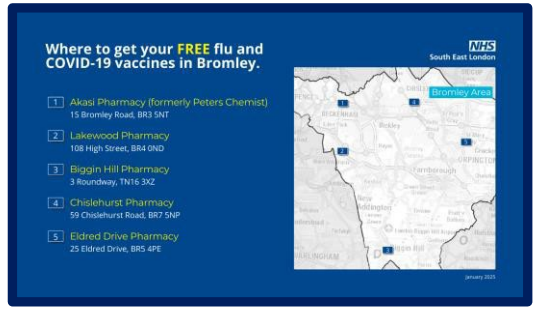
Ensuring vulnerable people are protected



<u>INITIATIVE:</u> taking a strong partnership approach, working together to ensure vaccinations are offered and easily accessible to all eligible residents, with a focus on those most at risk.

ACTIVITY

- Offered vaccinations with wide range of partners at accessible locations including GP practices, Community Pharmacies, Care Homes and at home for housebound patients.
- To increase access for our underserved communities, several community outreach clinics were also held.
- Organic and paid for social media advertising campaigns were deployed in order to reach at-risk groups with lower uptake.
- Following the launch of the year-round vaccine for Respiratory Syncytial Virus (RSV), we extended our Winter Resilience programme to include vaccinating relevant cohorts.

IMPACT

- Bromley was one of the best performing London boroughs for winter vaccination uptake.

COVID BOOSTER:

- **65.1%** of over 65s
- **20.1%** of under 65 at risk
- **63%** of housebound patients
- **74.4%** of Care home residents

FLU:

- **73%** of over 65s
- **41%** of those aged 18-64 at risk
- **39%** of those under 18 at risk
- **49%** of 2–3-year-olds

RSV:

- **54%** of eligible older patients vaccinated

(*Source: EMIS data 02.03.2025)

Hospital at Home

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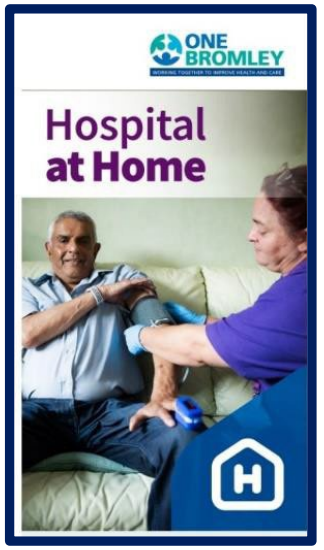
WORKING TOGETHER TO IMPROVE HEALTH AND CARE

Providing more care closer to home



INITIATIVE: the expansion of an award-winning initiative to provide more care closer to home, helping to prevent avoidable hospital admissions and support earlier discharge.

ACTIVITY

- During 2024/25, the adult service further developed its operating model and now directly pulls patients from the hospital, both attending board rounds but also supporting patients to transition into the service.
- Closer working with hospital consultants is providing a significantly increased virtual service, delivering a 50% increase in capacity from winter 2024/25.
- Virtual ward monitoring began to be delivered in-house, managed directly by the Hospital at Home team
- Developed a heart failure management protocol within the team.
- The children's service secured remote monitoring technology, further enhancing an already award-winning service.

IMPACT

- The Bromley hospital at home services, for children and adults, continue to go from strength to strength, with both helping to prevent avoidable hospital admissions and support early discharge.
- Between September 2024 – January 2025, virtual ward monitoring doubled, enabling early detection of deterioration following an acute episode and preventing readmissions or A&E attendances
- Since introducing the UCR liaison role, use of Hospital at Home and virtual wards has increased by 78.4%.
- The services have received several accolades including being shortlisted for a Health Service Journal Award and winning a LaingBussion award.

Mental health

Improving access to care for people with mental health conditions

INITIATIVE: working in partnership to offer a 'no wrong door' approach to ensure more children and young people access support when they need it

ACTIVITY

- In summer 2024, the Bromley Integrated Single Point of Access (ISPA) for children and young people's mental health and wellbeing opened.
- The ISPA brings together the NHS and voluntary sector into a common "no wrong door" approach, meaning that more children and young people with mental health and emotional wellbeing challenges will be able to access the right help in a timely manner.
- To build on this success, in 2025/26 the ICB will be taking forward the ISPA 2.0 project to further embed the service and ensure improved links to schools, social care and primary care.

IMPACT:

- The new ISPA has been a truly positive innovation in Bromley, with shorter waiting times, more early help and the delivery of a blended offer of tailored NHS and voluntary sector support for the first time.
- Improved access to the right service at the right time, through joint decision making, with the average referral to discharge from the iSPA being 7-8 days.
- More seamless service delivery, with a reduction in re-referral rates between services.
- Collaborative working, allowing for shared knowledge and expertise.

Medicines optimisation

ONE BROMLEY
WORKING TOGETHER TO IMPROVE HEALTH AND CARE

Optimising medicines at a patient level

INITIATIVE: working to continuously improve knowledge and best practice in Medicines Optimisation that improves patient outcomes.

ACTIVITY

- Launched the Prescribing Improvement Scheme to Primary Care Networks (PCNs) and followed up with individual practice visits, focusing on highest priority quality and cost-effective improvements. Offered support regarding Medicines Optimisation in Care Quality Commission inspections by providing management plans, templates and searches.
- Contributed to the development of South East London (SEL) medicines guidelines reflecting local priorities and implement at place through refreshed Medicines Implementation Group, newsletters, signposting & EMIS Referral Optimisation Protocol.
- Delivered expert training and interactive webinars to PCN pharmacists, GP registrars and Foundation Year 2 doctors covering Pharmacy First, Structured Medication Reviews, electronic tools, and de-prescribing in end of life. We also delivered a number of health promotion events such as ‘know your numbers’.

IMPACT

- Bromley prescribing 2024/25 was within allocated budget and exceeded Quality, Innovation, Productivity and Prevention (QIPP) targets, indicating cost effective, quality driven prescribing.
- The Medicines Optimisation Team helped standardise best practice across SEL and Bromley, promoting consistent and evidence-based, cost-effective prescribing, improving patient outcomes and long-term condition management.
- Increased delivery of patient-centred, adherence focused SMRs with improved patient understanding. De-prescribing to reduce waste, improve long term condition management and improve medicine safety. Fosters a more collaborative approach to Medicines Optimisation across the healthcare system.

Medicines optimisation

ONE BROMLEY
WORKING TOGETHER TO IMPROVE HEALTH AND CARE

Optimising medicines at a patient level

INITIATIVE: working to continuously improve knowledge and best practice in Medicines Optimisation that improves patient outcomes.

ACTIVITY

- Phase 2 of the South East London Community Pharmacy Health and Wellbeing Service went live with two providers in Bromley. To date this service has delivered over 5,000 vital 5 checks plus opportunities to discuss vaccine hesitancy.
- Over 1,000 Bromley patients with adherence concerns were reviewed by the Medicines Optimisation Service (MOS), de-prescribing and implementing individualised recommendations provided by community pharmacies. Service review and optimisations for MOS and Tailored Dispensing Service.
- The team worked collaboratively with Community Pharmacy Neighbourhood leads to promote and optimise services including pharmacy first and @BP.

IMPACT

- This contributes to improve health and wellbeing for local communities especially those not accessing other healthcare settings, focused on the most deprived localities, identifying key health risks and supporting early interventions.
- Collaborative working improves reconciliation and Structured Meciation Reviews, reduced risk of medicine related harm including hospital admission avoidance, supporting continuity of Tailored Dispensing Service.
- service with innovative solutions tailored to individuals.
- Improved access for seven conditions and minor ailments via 111 & Urgent and Emergency Care with communications delivered to optimise healthcare providers and service users understanding.

Building the Bromley Workforce

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WORKING TOGETHER TO IMPROVE HEALTH AND CARE

A successful partnership recruitment fair

INITIATIVE: working in partnership to connect our community with meaningful employment and volunteering opportunities

"It was fantastic. I've managed to speak to quite a few employers as I've been out of work for a while. I visited tables like Mind and Community Links." **(Attendee)**

ACTIVITY

- The Bromley Partnership Recruitment Fair held in October 2024 was a collective effort with the Department for Work and Pensions (DWP), the Borough Partnership Board and the South East London Health and Care Jobs Hub supporting the event.
- The Fair attracted large numbers due to extensive promotion including targeted social media, electronic advertising boards in the Glades, graphics on GP screens, staff newsletters, online information, a press release and printed flyers were widely distributed.
- Residents explored a diverse range of opportunities, meeting local public sector and voluntary sector employers such as the NHS, Social Care services, Mytime Active, London South East Colleges, London Metropolitan Police and the London Fire Brigade.

IMPACT:

- 591 local residents attended the Fair.
- Numerous attendees were subsequently offered paid roles, including eight carers recruited by Bromley Healthcare.
- Volunteering positions were offered by Bromley Mentoring Initiative and Bromley Third Sector Enterprise partners.
- The Metropolitan police spoke to over 300 people at the event and noted it was excellent engagement for them.
- The SEL Health and Care Jobs Hub signed up 15 individuals on the day who are all now being supported, and one person has been offered a role so far.
- Due to the success of the event, it has been suggested to run another Bromley recruitment fair in 2025.

One Bromley Cadets Programme

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WORKING TOGETHER TO IMPROVE HEALTH AND CARE

Inspiring our young people

<u>INITIATIVE:</u> encouraging our young people to explore careers in healthcare, broadening horizons and offering real insights.

ACTIVITY

- The programme, for 16-19-year-olds, who are interested in a career in health and care, in 2024/25 was expanded to allow for more students per cohort including young carers and care leavers.
- Schools promoted the programme to students less likely to secure such opportunities for insight or work experience elsewhere.
- We ran two cohorts per academic year offering the opportunity for immersive experiences within community, primary care, and hospital services during after school sessions.
- In addition, an online pilot focused on Medical Careers for years 11-13 was offered, allowing for a larger number of students to join.
- A tailored face-to-face health and care careers session was also delivered for young carers, with the chance to hear from clinical and non-clinical professionals on their career pathways.

IMPACT

- We have delivered seven cohorts with 151 students, from eight local schools, home schooled individuals, young carers and care leavers.
- Feedback from both students and schools is excellent, with an average rating of 3.7 out of 4.
- 100% of the Cadets either agreed or strongly agreed that they would recommend the Cadets programme to future students, they also indicated that they had increased their knowledge and understanding significantly.

One Bromley Recognition Awards

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Celebrating our achievements and collaboration

<u>INITIATIVE:</u> shining a light on the progress that can be made when we work in partnership, taking a moment to celebrate each other.

ACTIVITY

- The One Bromley Recognition Awards 2024 celebrated staff and team achievements and the spirit of partnership that drives the continuous improvement of health and care services in the borough.
- 200 staff from health, care, and voluntary services came together to celebrate successful collaboration and partnership working.
- 13 awards recognised exceptional staff and teams who had proven outstanding joint work with two or more health and/or care organisations in Bromley.
- Staff expressed gratitude at being recognised and valued for the joint work they do that improves the health and wellbeing of our residents.

"I am immensely proud of Bromley's great partnership work, which together helps promote good health and wellbeing across the borough. Remarkable progress is being made by improving the way residents can find and use health and care services, resulting in a more inclusive and equitable healthcare system for all our residents".
The Mayor of Bromley, Councillor David Jeffreys

WINNING TEAMS

- Referral Optimisation Protocol
- One Bromley Homeless Project
- Bromley Care Home Multi-disciplinary Team Intervention Programme
- One Bromley Learning Disability Taskforce
  One Bromley Adult Hospital at Home service
- The One Bromley Cadets Programme
- Enhanced Care Team
- 'Know your numbers' blood pressure awareness campaign
- Orpington Wellbeing Café
- One Bromley Community Health Champions
- Bromley Children's Health Integrated Partnership
- One Bromley Recruitment Campaign
- One Bromley Winter Illness Hubs

Other highlights and achievements

Other developments

ONE BROMLEY
WORKING TOGETHER TO IMPROVE HEALTH AND CARE

Highlights and achievements

Bromley Well

- The BTSE operated Bromley Well service continued to thrive:
  - Supporting 10,122 individuals across the year, of which, some 33% were disabled.
  - Helping residents to claim £3.8m of benefits they had been struggling to access.
  - Supporting 1,261 Carers and 3,000 elderly and frail people through hospital aftercare, advice, befriending and handyperson services.
  - Leading on the One Bromley Carers Charter launch, which outlines a shared approach on improving how unpaid carers are engaged, supported and consulted.
  - Delivering an action plan of promotion, staff training, identification and information for carers.

Bromley GP Alliance

- The Bromley GP Alliance celebrated its 10th year and is proud to be supporting Bromley residents with 18 different services including:
  - Providing Phlebotomy 140,000 appointments annually across 10 sites.
  - Winter Illness Hubs, providing 10,000 additional GP appointments during the winter.
  - Bromleag Care Practice, one of the first GP Practices to support people living in a care home setting.
  - The award-winning BGPA Homeless Health Project, in tandem with Bromley Homeless Charity.

Other developments

Highlights and achievements

Bromley Healthcare progressed several initiatives over the year including:

- Expanding the Children's Hospital at Home service by rolling out a step-up service from primary care for children with respiratory conditions, providing earlier intervention to prevent escalation.
- An 18-month pilot introducing remote monitoring for children with respiratory conditions, enabling closer monitoring and early intervention was also launched.
- The launch of a Health Inequalities Dashboard to help community healthcare services identify inequalities and tailor interventions to local populations.
- Development of a new Talking Therapies website with patient-led user testing, making it easier to access self-referrals and self-help resources.
- Introduction of an innovative new swallowing therapy for Parkinson's patients, funded by Parkinson's UK.

Other developments

Highlights and achievements

St Christopher's continued to support Bromley residents with palliative and end of life care throughout 2024/25 including:

- Increasing the number of recipients of holistic care and support with increased bed days, additional home and community visits.
- Supporting more residents to engage in wellbeing activities, with significant uptake in Art and Music Therapy consultations when compared with last year.
- Working closely with Bromley Healthcare to grow the Hospital at Home service, allowing for 66% of all referrals to be seen within four hours and a further 20% to be seen within 24 hours. In addition, over 50% of those who stayed on the Hospital at Home service received ongoing care from the Community Team on discharge.
- The Senior Care Directorate worked to improve the effectiveness of the community service provision to provide an improved experience at the beginning of the journey via a new Front Door model. Third party referrals are now triaged immediately with a same day call from a Senior Nurse in the Community Team to the patient or family, a brief risk assessment is undertaken and an agreed date for a community visit is made.
- Continued to work collaboratively to develop work in heart failure, frailty and also improving care offers by attending the Integrated Clinical Network meetings.

Other developments

Award wins and nominations

- The Clinical Director for Adult **Hospital at Home**, Dr Lynette Linkson was shortlisted in the **'Clinical Leader of the Year'** category at the **HSJ Awards.**
- **Hospital at Home** was also recognised at the **LaingBuisson** awards, achieving a win in the **'Primary Care and Diagnostics'** category.
- **The Orpington Wellbeing Café** was shortlisted in the '**Improving Care for Older People**' and the '**Primary Care Initiative of the Year**' categories at the **HSJ Patient Safety Awards**.
- **Bromley Homeless Project** was shortlisted in the '**Best Use of Integrated Care and Partnership Working in Patient Safety**' category at the **HSJ Patient Safety Awards**.
- **Orpington PCN Pharmacy** team won '**Pharmacy Team of the Year**' at the **General Practice Awards.**
- **Bromleag Care Practice** was commended in the '**Safety Award'** category at the **London General Practice Awards.**

ENCLOSURE: 6
AGENDA ITEM: 8

ONE BROMLEY
WORKING TOGETHER TO IMPROVE HEALTH AND CARE

One Bromley Local Care Partnership Board

DATE: Thursday 27th March 2025

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	None.	
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, Bromley Public Health.	
Clinical lead:	Not Applicable	
Executive sponsor:	Dr Angela Bhan, Place Executive Lead	

ONE BROMLEY
WORKING TOGETHER TO IMPROVE HEALTH AND CARE

Partnership Report – March 2025

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1. One Bromley Local Care Partnership Programmes

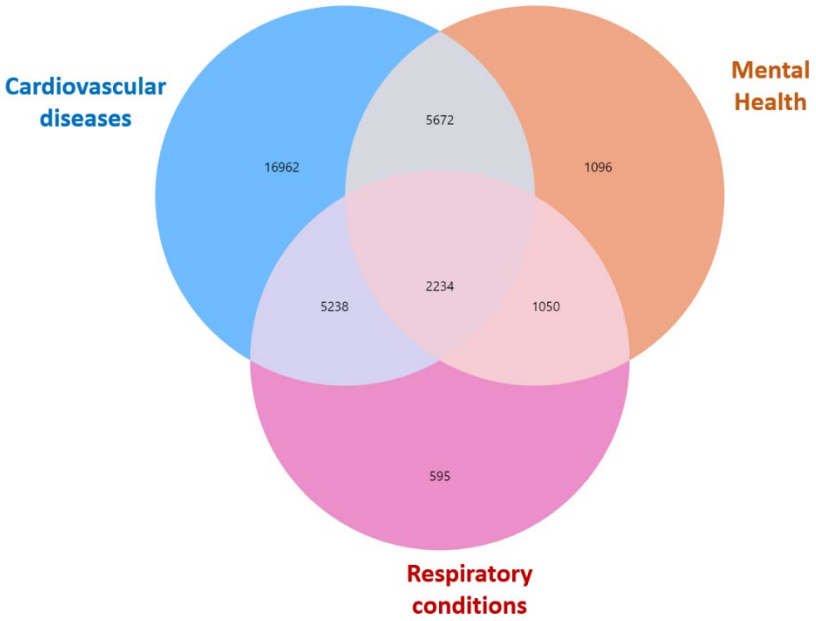
Multiple Long Term Condition Management

Bromley is an important part of South East London's work on improving outcomes for people with three or more long term conditions. The work is focussed on people who have a rising risk of deterioration and increased use of unplanned care services. People who are identified as potentially frail will be transitioned to the frailty pathway.

The Bromley Clinical Advisory Group has recommended the work commence with people who have three or more long term conditions, at least one of which is cardiovascular disease. This maps well with international evidence on drivers of high care and health utilisation for populations. In Bromley this suggests that there are 14,500 people under the age of 75, or 30,000 of all ages in these categories, recognising some of these groups will be living with frailty. The work is further looking at the health inequalities experienced by a sub-set of this group, examining the overlap with living in a Core20 area, being a member of an ethnic minority group, or having another vulnerability.

Through this data-driven approach to understanding our population, Bromley is aiming to target resources to achieve best outcomes for all our populations and to deliver a 'left shift' towards prevention. The pathways will work with individuals who are identified, to understand their holistic needs, medically optimise their care, link people with relevant voluntary sector, care and health services, and provide ongoing co-ordination support based on need. A key next step for the programme is working with developing integrated neighbourhood teams to establish the model on the ground.

Population with 3+ Long Term Conditions, registered with Bromley GP, split by three disease groupings



Frailty and ICN Development

Integrated Care Networks (ICNs) in Bromley, bring together a range of health and care services to work in a more joined up way to provide care for patients. We currently have three ICNs in Bromley, each covering around a third of the population that deliver weekly multi-disciplinary team meetings. This model of care aims to prevent ill health and unnecessary emergency admissions to hospital by proactively supporting patients who are frail, vulnerable or who have complex long-term conditions.

Between April 2024 and February 2025, 1060 ICN multi-disciplinary team meetings were held for 1021 patients with 1020 medication reviews completed. This included representatives attending from General Practice, Community Care, Mental Health, Social Services, St Christopher's and the voluntary sector. Using this approach to work together is improving quality of care and outcomes for patients as well as reducing demand for emergency care at the Princess Royal University Hospital.

Recently, the following initiatives have been taken forward for frailty including:

- A case management pilot to support complex patients who need additional care for a short time after an ICN assessment. Case management has been expanded to four Primary Care Networks including Orpington, Crays, Mottingham, Downham & Chislehurst and Beckenham based on the highest number of referrals. From April 2024 to date, 125 patients have been through the case management pathway. There has been a 71% improvement in wellbeing scores which is recorded at the patients first visit and then their final visit before discharge.

- Across Bromley, we have piloted a multi-disciplinary, multi-organisational review process for care and nursing home residents most at risk of admission to hospital. This has resulted in the updating of patient universal care plans used by the London Ambulance service and others so our health and care system can better ensure appropriate care and treatment for some of our most vulnerable patients. With greater care being provided in the community, there has been 24% fewer 999 calls and conveyances across the wider patient group in all care home settings involved in the pilot.
- The Acute Frailty Assessment unit at the Princess Royal University Hospital has expanded to take direct referrals from local community providers and the London Ambulance Service alongside the Emergency Department. This has enabled individuals to be assessed before being discharged home with a care plan or transferred to the relevant medical service for further treatment.
- An anticipatory care dashboard has been developed to help identify the most complex patients who are greatest risk of hospitalisation.

During 2024/25 there has been a continued focus on frailty in Bromley, two new frailty and older people clinical and professional leads were recruited and have taken the opportunity to review and refresh the frailty strategy. Several stakeholder events have been held which have informed our immediate priority areas including:

- The use of consistent frailty recognition tools such as clinical frailty scores and universal care plans to drive pathway decisions and patient conversations.
- The roll out of standardised frailty competency training to upskill the workforce.
- Consistent health messaging and greater understanding of frailty provision to help drive the preventative agenda and wider use of community assets.

One Bromley will continue to bring together providers, voluntary services and commissioners to build on the existing good work. For 2025/26, plans are underway to deliver frailty services using an Integrated Neighbourhood Team (INT) approach. This will incorporate a wide range of frailty services currently being provided with a greater focus on prevention, coordinated proactive care and de-escalation of crisis.

Diabetes

Diabetes is a high priority long term condition within Bromley. 18,871 people are living with diabetes. 1,314 people with Type 1 diabetes and 17,154 people with Type 2 or other diabetes diagnosis. That is a prevalence of 5.2% of the registered population of Bromley.

Public Health England estimate 29,872 people in Bromley are at risk of developing diabetes. If obesity trends persist, one in three people will be obese by 2034 and one in ten will develop Type 2 diabetes. There is evidence that many cases of Type 2 diabetes are preventable.

The Diabetes Partnership Group meets regularly and includes representation from across the One Bromley LCP. It works collaboratively to share best practice, work to resolve issues and gain feedback from patients with lived experience of diabetes care.

There are already a number of prevention, weight management and education initiatives for Bromley residents:

- National Diabetes Prevention programme
- 9-Month and 3-month courses.
- Walking Away from Diabetes
- Type 2 Diabetes total diet replacement

Bromley Healthcare and Primary Care work in partnership in delivering care to people living with diabetes. Bromley Healthcare provide specialist diabetes care and support the APCP (Advanced Primary Care Practice) programme, which has aims to improve care for patients living with diabetes in Bromley.

Kings College Hospitals (PRUH) provide inpatient care for patients living with diabetes as well as a multidisciplinary footcare service and has also developed several new initiatives including a 'D-Ward' to support the earlier discharge of people with diabetes. PRUH also provide best practice care for children with diabetes, transition services and antenatal care.

Working in partnership, several projects have also been delivered in 2024/25 as well as some that are being developed for delivery in 2025/26.

Healthy.io – A 1 year project ending 2024, this project enabled home urine testing for cohorts of diabetes patients. This project led to increased coverage of ACR testing.

Diabetes Outcome scheme – A 2-year scheme, which worked with PCN's and the Health Innovation Network to improve the diabetes 8 care processes. Improvements were seen across practices and PCNs across all care processes along with improvements within variation amongst primary care.

SMI and LD Diabetes analytics – A project to investigate statistics of diabetes outcomes for SMI and LD patients. This is currently underway.

Early Onset Type 2 Diabetes – A new project currently being planned and set for delivery in 2025/26, will focus on extended appointments for a cohort of Type 2 diabetics with extended appointments.

Diabetes transformation – A wide-ranging review of the diabetes provision across the Bromley system. Planning commenced in 2024/25 and will continue into 2025/26 to ensure the Bromley diabetes is delivering the best practice it can, is sustainable and meets the changing needs of our population.

2. Princess Royal University Hospital and South Sites

Princess Royal University Hospital (PRUH) Site Chief Executive Update

Finance

Current deficit position

For the eight months of this financial year to November, we recorded a deficit of £18.4m. This is a £12.3m improvement on the target deficit of £30.6m that we set ourselves in our plan to the end of November 2024.

Cost-improvement plans

As previously reported the Trust Board committed to delivering £50m of cost saving initiatives. As of 30 November, £50m worth of cost-saving initiatives have been identified, agreed and are now in the process of being delivered.

Referral to treatment – Elective Care

The number of patients on our waiting list for the trust reduced from 92162 at the end of October 2024 to 87475 at the end of November (reduction of 4687). At the end of November, the Trust had 37 patients who waited 78 weeks or more. At the end of November, the Trust had 375 patients who waited 65 weeks or more. A full action plan is in place to eliminate all 65 week waits.

Emergency Performance – PRUH and South Sites

October attendances were at an average of 385 per day this increased from September with attendances at 366 per day. November's position and performance was maintained at 70% which is above the SEL agreed trajectory. Our 12-hour Decision-To-Admit breaches remained static during November at an average of 17 per day at PRUH. Performance for November was 8% higher than November last year whilst seeing a 6% increase in patient attendances for the same comparative period. New ADU embedded and Type 1 performance has improved as a result. Increased daily SDEC volume following the opening of the new unit. Ward discharges have increased by an average of 5 per day compared to last year.

Cancer

The Trust continues to see a consistent improvement to cancer performance over the last 7 months. Cancer treatment within 62 days of post-GP referral is ahead of the SEL agreed trajectory, delivering 65.90% for October with PRUH achieving 78.5%. Faster Diagnosis Standard compliance was above target at 80.27% in October against the national target of 70%. 31 day performance for the Trust for October was 88.07% with PRUH's performance at 93.7%. Backlog reduction continues to improve.

Diagnostic Performance

Challenges continue with regards to diagnostic testing of patients within 6 weeks. The Trust submitted November performance of 45.31% across both sites, this is above our revised trajectory of 32.8% (and therefore continuing to be above the 2024/25 Operating Plan national target <5%) which is an improved performance from 45.77 in October. The number of 6+ waiters increased by 63 patients from 12,916 waiters in October to 12,979 waiters in November.

Actions being taken include:

- The pilot to transfer non-obstetric ultrasound (NOUS) patients to Eltham CDC has been paused due to a number of issues related to the lack of digital interoperability between the CDC clinical information system and Epic. The CDC clinical system is not due to be upgraded until May 2025 and plans to enable the re-start of transfer of NOUS pathways in the intervening period need to be finalised.

- System mutual aid for neurophysiology to support capacity challenges commenced and will be ongoing in H2.
- System mutual aid for paediatric sleep studies due to significant staffing issues commenced from September.
- The Trust Diagnostic recovery plan has been signed off with targeted capacity increases in MRI, NOUS and ECHO and is now in implementation phase.
- Additional validation of overdue surveillance and DM01 backlog pathways will be provided by an external consultancy, Ideal and is being funded by APC monies initially. This work is due to commence in early-January 2025.

Apollo/EPIC

Staff across all KCH hospitals and locations continue to work from one integrated patient record, Epic. Almost 600,000 patients have registered for MyChart across King's and GSTT with 230,152 of these at King's. Patients using MyChart are less likely to miss (DNA) their appointments in December KCH patients DNA rate was 5.0% rather than 11.1% for non-MyChart patients.

315,883 test results have been released to patients via the app in February 2025, and 188,212 pre-appointment information forms have been completed in February 2025, providing clinical teams with key information ahead of consultations.

Estates

Our extensive capital programme continues;

Endoscopy Unit

Construction is now well underway. The building superstructure is complete and internal fitting out is underway. Internal walls have been completed, and first fix services are underway. The project has a two week delay.

Radiology Upgrades

Mammography replacement remains under review.

Flow upgrades and other developments

A range of other capital projects across the PRUH are being undertaken.

Day Surgery Unit

Structural improvements and fire protection have been completed. The backlog maintenance program work is now underway for theatre improvements, new pendants, surgeons panels and air handling replacement. This is expected to be completed by the end of March.

Other major works being undertaken by the PFI are roof replacement work, theatre main air handling equipment replacements, nurse call replacement, fire alarm replacement, street lighting replacement and generator panel upgrades.

Orpington - Back log maintenance work is also underway including window replacements, roof repairs and water systems.

.3. London Borough of Bromley - Adult Social Care

The Digital Transformation Programme, with delivery partner The Social Care Institute for Excellence, continues to be a top priority for Adult Social Care in LBB. We are now 4 months into the Discover and Design Phase and have effectively mobilised the Programme across Adult Services. The first five priority projects are live, and some have established trials to test new ways of working across the Service. These are:

- AI Transcription pilot;
- Online Improvements (Website, Portal and Community Assets);
- The delivery of enhanced Assistive Technology (AT) investment pilots;
- Enabling process changes to underpin the delivery of the change programme
- Improving decision making through the development of new performance dashboards

Work to strengthen co-production by developing and implementing a new Adult Social Care Co-Production Strategy, to ensure residents are shaping services alongside us, is also underway. Finally, significant progress has been made on the Front Door Transformation which was co-produced with staff across the Council, people with lived experience, carers, and the Voluntary, Community and Social Enterprise (VCSE) sector partners. The proposal, to pilot a new operating model for 6-12 months, was finalised in December 2024 and is due to launch in April 2025. It is expected to result in improved waiting times to access care and support and reduced packages of care.

Financial pressures continue, with an increased overspend forecast in year. This is as a result of the cost of care, rather than more people accessing care. We are about to enter 2025/26 with heightened expectations of providers around fee increases in light of inflationary pressures, employers national insurance and increases to the living wage. We continue to balance the need to support market sustainability against working within the council's financial envelope.

Preparation for CQC assurance continues. The Council has not yet received notification from the CQC of assurance activity, but the CQC have now announced the date of each month between now and September when notifications will be sent out. One local authority, Camden, have received an 'Outstanding' rating and we look to learn from them and the experience of others in our own preparations.

4. St Christopher's Hospice

Refurbishment of in-patient unit

St Christopher's are undertaking a significant building project over the next 9 months where we will be renovating our inpatient spaces. We are aiming to improve the patient bedrooms in addition to staff areas. The work starts in mid-April and will be finished by the end of the calendar year. As the work progresses it will be necessary to close some beds to allow the work to be carried out and also to protect the people staying at the hospice from too much noise.

St Christopher's will continue to take referrals for inpatient care in the usual way and will work hard to maximise the use of beds particularly in relation to timely discharge for people who are well enough for onward transfer.

This information has been communicated externally to ICB's, Primary Care and Acute Hospitals. We have asked external colleagues to discuss with people they are referring to the inpatient unit that their stay will have some noise disruption and that the team are hoping to keep to a minimum.

Assisted Dying Update

St Christopher's has submitted written evidence to the Terminally Ill Adults (end of Life) Bill parliamentary committee. The areas we addressed included:

- Mental Capacity Safeguards
- Prevention of Coercion
- Multi-Disciplinary Team approach
- Equity in Practitioner Opt-out
- Support for individuals from disadvantaged backgrounds
- Cultural competency training

Following feedback from staff we held five concurrent sessions exploring conversations related to Assisted Dying based on case studies, 100+ staff attended.

We also held two online sessions giving an update on Assisted Dying for volunteers with 140+ attending.

Community Research on public viewpoints on Assisted Dying

Re-branding

Over the last year we have been introducing our new brand across our two sites in Sydenham and Orpington, as well as across our 24 shops.

5. Bromley Healthcare

Bromley Healthcare colleague wins Rising Star EDI Award

Donya Gaye, our equality, diversity, and inclusion lead, has won the Rising Star Award at the recent South East London ICS Equality, Diversity, and Inclusion (EDI) Awards. This award recognises emerging leaders who have demonstrated significant achievements in advancing EDI.

Since joining Bromley Healthcare, Donya has raised the profile of EDI across our services and has been pivotal in launching initiatives such as the Diverse Abilities Network. She co-delivers our Recruitment & Selection training, ensuring inclusive practices and clear processes for reasonable adjustments. Donya also led a successful internal EDI conference, creating resources that colleagues can continue to access on the BHC intranet, and has raised internal awareness and understanding of the Freedom to Speak up process, empowering colleagues to raise concerns about unsafe patient care, colleague safety, working conditions, bullying or suspicions of fraud. Donya's innovative approach and proactive leadership are driving real changes in how we address equality, diversity, and inclusion.

Annual Bromley Healthcare colleague awards celebrate excellence across our services

We recently celebrated outstanding achievements across Bromley Healthcare at our annual Colleague Awards event. The awards recognised staff and teams who have made a significant positive impact on patients, colleagues, and services. This year, we were pleased to include representation from our Lived Experience Advisory Group (LEAG) on the judging panel, bringing in patient perspectives informed the selection of winners.

Estates accessibility reviews – working with service users

As part of an ongoing estates review, our transformation team has started conducting accessibility audits at Bromley Healthcare sites, collaborating with a service user who has multiple complex disabilities. The team is directly gathering valuable insights on how we can practically improve accessibility at our locations, making sure that real-world experiences shape our actions, and developing accessibility guides for all our services (example here: Accessibility – Children's Bladder and Bowel). The resulting recommendations and improvements will be shared widely, enabling colleagues and partners to benefit from this patient-focused approach to improving accessibility.

Integrated Adult Therapies Service – New leadership and joined-up approach

We've recently appointed Robyn Ridgeway as our new Integrated Adult Therapies Service Lead. This role combines our Rapid Access to Therapies, Adult Occupational Therapy, and Adult Physiotherapy teams into one integrated service. By bringing these areas together under Robyn's leadership, we are aiming for more seamless care, improved patient experiences, and enhanced collaboration between therapy teams. We look forward to sharing our learnings from this approach with our One Bromley partners.

Launch of new weekly virtual drop-in for complex foot ulcers

Our podiatry wound care lead, Emma Kokkinaki, has recently set up a weekly virtual drop-in clinic to discuss complex foot ulcer care with nursing colleagues in Bromley. These sessions enable teams to discuss cases, review wounds remotely using a photography app, and plan treatment collaboratively, ensuring patients receive well-coordinated, timely care. Early feedback shows this initiative is already helping colleagues improve clinical outcomes and reduce unnecessary visits.

6. Oxleas

Child and Adolescent Mental Health Services

The waiting time for initial assessment by Bromley CAMHS continues to reduce in line with regional targets. Work is currently focused on reducing the maximum wait for initial assessment to within 30 weeks by April 2025. Oxleas are publishing average assessment waiting times for Bromley CAMHS on our website: Oxleas NHS Foundation Trust - Bromley CAMHS.

In January 2025, our average waiting times per care pathway were:

- Adolescent: 1 week
- Generic: 16 weeks
- Looked After and Adopted Children: 1 week
- Neurodevelopmental and Learning Disability: 19 weeks

Work also continues in Bromley CAMHS to review and improve the clinical pathways and further develop the support offered to children, young people and their families while waiting for assessment or treatment. This includes the mobilisation of an Oxleas CAMHS Universal Pathway to reduce unwarranted variation and ensure care is delivered in line with best practice.

We are also working actively with system partners to improve the broader service offer for children and young people in the borough, ensuring that services are aligned to the national recognised THRIVE framework. As part of this, we continue to deliver an integrated Single Point of Access (iSPA) with our partners at Bromley Y. This service is the front door through which children, young people and their families access mental health and wellbeing services in Bromley.

Acute and Crisis Mental Health Services

There continues to be high demand at emergency departments and through our crisis line. A significant number of "unknown" patients are presenting as acutely unwell needing inpatient admission. Also a significant number of patients describe challenges relating to finances, housing, relationships and general social support.

To meet this demand, we have continued to use beds in the private sector. In response, we are planning to open a 16 bed mixed adult acute ward at the Oxleas House site in October 2025.

We are working with partners to find care home placements and supported accommodation for patients who are ready to leave our wards.

Older People's Services Conference

Oxleas' first trustwide Older People's conference was held in February to share the exciting work being done across our services to improve the health and wellbeing of people in later life.

Chaired by Chief Medical Officer, Dr Abi Fadipe, keynote speakers included Dr Amanda Thompsell, National Advisor of Older People's Mental Health at NHS England, and Dr Jan Oyebode, Professor of Dementia Care at the University of Bradford.

The conference included presentations, posters and interactive stalls from colleagues working within community mental health, acute and crisis, adult learning disability, adult community health and forensic and offender services.

National apprentice week celebrations

We supported February's national apprentice week by sharing how our colleagues and our services have benefitted from the career opportunities offered through the scheme. A member of our district nursing team Teressa Riley was featured in The Guardian newspaper showcasing her apprenticeship journey with the University of Greenwich. We also took part in apprenticeship events in local schools to highlight the opportunities on offer.

7. Bromley Third Sector Enterprise (BTSE)

Bromley Well

Our services continue to experience high demand, with the first months of the year a time when we receive an increased number of cost of living issues. We have also seen an increase in demand for our Older People's Information and Advice Services including pensions and benefits checks. We receive referrals across the adult age range, however our largest is those aged 55-64.

Our Hospital Aftercare services continue to perform effectively with 1409 patients supported by our Take Home and Settle Service since April 2024 and 361 since the start of January. 96% of these were collected within 30 minutes of discharge. This is in significant part due to the work of care navigators at the PRUH. Our Post-Discharge Settling Service received over 100 referrals. The Handy Person Service is facing significant demand, which has increased over the past year, and is currently delivering at well over 200% of its KPI

Service Issues

Cost of Living issues, particularly changes to Winter Fuel allowance, continue to be significant across pathways, notably for those with disabilities, as well as a further increase in demand for foodbank vouchers and advice on housing. We have seen a notable increase in those accessing our disability support services, physical disabilities in particular where the number of new clients last quarter was 100, 66% more than KPI for this service.

Carers

The Carers Charter rollout continues with engagement with stakeholders including Bromley Healthcare. Positive meetings have been held with GPs and a GP training session took place online on 13 March. We are also developing plans for Young Carers Action Day on 12 March and Carers Week 9-16 June, where we will provide a 'one year on' update on the Charter.

Glades Wellbeing Hub

The new One Bromley Wellbeing Hub in the Glades has seen significant client numbers of 156 clients being advised June-Dec. One Bromley confirmed additional Winter capacity including

Cost of Living support from January-March 2025. We now have both information and advice and older people's advice on Wednesday and Friday.

The Hub has been extended to March 2026 and the drop -in information and advice offer on Wednesdays will continue. This is the only drop-in advice service in central Bromley.

8. Primary Care Networks (PCN)

PCNs promoting digital literacy

Bromley PCNs were out in force at the recent digital literacy campaign taking place at several libraries across the borough at the end of January in support of the national health information week. PCN teams worked alongside One Bromley and Bromley Council to help patients understand the benefits of the NHS App when booking GP appointments, ordering repeat prescriptions and accessing services from their phone or computer. PCNs are aiming to continue to develop this collaboration as a new way of outreach to their patient populations.

Year end targets for Impact and Investment Fund

This year there were two clinical care targets under the Impact and Investment Fund (IIF) scheme for PCNs:

- Annual Health checks for patients with learning disabilities
- Faecal Immunochemical Test accompanying, within 21 days, lower gastrointestinal cancer two week wait (2WW) referrals.

The Bromley Learning Disability Champions deployed in each PCN since October 2024 continue to provide targeted support to practices to increase the number of health checks completed. All PCNs are on course to achieve both IIF targets at the end of March.

New PCN leadership roles announced

Following the start of intensive work on planning a model of neighbourhood working for Bromley in line with the expectations set out in the Fuller Stocktake for local systems, a new PCN leadership role has been announced in acknowledgement of the key role that General Practice will play in developing this new way of working.

Drs Bridget Hopkins and Claire Riley, Bromley GPs and PCN Clinical Directors, have been appointed as PCN Clinical Leads (Strategy, Neighbourhoods and Interface) and will take on a leading role in collaboration with the ICB and One Bromley to continue to build the primary/secondary care interface, leadership of the programmes to improve the sustainability of primary care and the development of Integrated Neighbourhood Teams (INTs) in Bromley.

Bromley Survey to GPs and Consultants on patient referrals

As part of the local drive for improvements to the primary and secondary care interface, a survey was circulated to all Bromley GPs in December 2024 which revealed that 98% of GPs received referral requests that should have been completed in secondary care. These requests were found to have a time implication for clinical and admin staff in primary care with a portion of GPs also taking time to communicate back to secondary care about these onward referral requests. The GP survey also showed that only 23% use the Quality Alert system to report inappropriate onward referral requests owing to lack of time and lack of feedback, and that GPs diligently manage workload that is deemed inappropriate.

The Bromley Interface Task and Finish Group is looking at how awareness can be raised amongst secondary care colleagues, including via joint teaching sessions for PRUH teams. A referrals survey to Consultants was distributed at the beginning of March and the responses will be reported in due course.

GPs education session on Discharge Summaries at the PRUH

A recent Discharge Summaries Workload Impact Review, sponsored by the ICB, was conducted between September 2023 and September 2024 in response to GP feedback about the increased workload associated with the increased volume of Docman files being received from secondary care. Docman is a tool used to digitally transfer letters from secondary care into a virtual ‘waiting area’ on the GP practice clinical system to be individually actioned and filed into GP records. This showed a 22% increase in document volumes, a 525% increase in duplications, a double in the number of pages per clinic letter and 77% with GP actions not clearly indicated. As a result, GP practices are having to hire extra staff or redistributing the work putting further strain amongst existing staff members.

In response, PCN clinical leads Drs Bridget Hopkins and Claire Riley met with resident doctors at the PRUH to look at the quality improvement projects already under way to improve discharge summaries and the patient journey. They were able to share how the documents are viewed in primary care in order to make further improvements and GPs will be surveyed to see if the changes have had a positive impact. This work is demonstrative of the continued drive

towards collaboration and closer working relationships with secondary care colleagues to benefit the patient journey.

PCN Showcase

Bromley Connect PCN	
Total list size	40,699
Member practices	Dysart Surgery, South View Partnership, London Lane Clinic
PCN base	All 3 practices
PCN infrastructure	3 CDs, one from each practice 3 Practice Managers, one from each practice 1 Administrator
ARRS staff	2 GPs 2 Clinical Pharmacists 4 General Practice Assistants 3 Pharmacy Technicians 3 Social Prescribers 2 Mental Health Practitioners 2 First Contact Physiotherapists 4 Care Coordinators
Population health data highlights	A lower prevalence for asthma and hypertension compared to other Bromley PCNs. The PCN has subsequently been working on our prevalence.
Hub services	PCN operates a hub model for GP appointments. We also have a daily hub triaging and actioning eConsults for the PCN. We also run BP @ Home as a hub.
Health Inequality project	Our inequality project focuses on housebound patients. All housebound patients are reviewed and offered personalised care visits. We are also working on visiting diabetic housebound patients. Our nursing team are visiting patients at home to ensure they receive their 8 care processes. The PCN is also in the process of creating 3 events for our dementia patients and their carers. Helping them connect to support in the local area and personalised care reviews with surgery staff.
Capacity and Access improvement initiative	Our PCN leaves our eConsult service on from Sunday 6.30pm to Friday 6.30pm. Our patients know they are able to contact us at their convenience and not worry about the service being unavailable.
Flagship service	Our PCN eConsult hub. Our hub works through the day triaging eConsults and supporting patients. During the day

	GPs, physios, pharmacists and GP assistants will work in our smart inbox to ensure patients are receiving care in a timely manner.
Future plans	The PCN has been working hard on providing BP @ Home at hub level so have structures for hub working in place for future programs that can be done at hub level.

9. Bromley Public Health

SmokeFree Bromley

Smoking tobacco remains the 'single most important entirely preventable cause of ill health, disability and death in the UK' (Government policy paper 'Stopping the start: our new plan to create a smokefree generation', October 2023). The Government made achieving a reduction in smoking prevalence a key priority with the publication of that paper, accompanying it with a smoking cessation ring-fenced grant to local authorities. The Government's commitment to creating a smoke-free generation has continued in the Tobacco and Vapes Bill currently going through parliament, alongside continued support for local authority-led stop smoking services through the ring-fenced grant.

Smoking prevalence in Bromley is currently estimated at 9.78%. In line with the national priority and Bromley's Joint Local Health and Wellbeing Strategy 2024-2029 (Priority 3: Disease prevention and helping people to stay well), Public Health has commissioned a new community stop smoking service to commence on 1st April 2025. This replaces the temporary pilot service that started in January 2024 and is ending in March.

Change Grow Live (CGL) is the commissioned provider for this new Specialist Stop Smoking Service, SmokeFree Bromley. CGL is already known in Bromley for providing substance use support: CGL Bromley (for adults) and Bromley Changes (for young people).

SmokeFree Bromley will be a separate, comprehensive stop smoking service, delivering specialist behavioural support and provision of appropriate medication to address nicotine addiction e.g. nicotine replacement therapy (NRT), prescription medication, and/or starter kits for vaping. The available evidence base shows that this combination of behavioural support and medication is the most effective method to quit smoking.

SmokeFree Bromley will be advertised widely across the borough and CGL will provide an extensive programme of training to ensure referrals into the service are maximised. There will be face to face and remote service provision as well as an offer of digital applications to support smoking cessation interventions.

The new Stop Smoking Service has been designed with a degree of flexibility to respond to the changing smoking cessation landscape in terms of legislation and potential variation to the scope and value of the requirements of the Government's smoking cessation ring-fenced grant. SmokeFree Bromley will work closely with a range of local partners through the Bromley Stop

Smoking Partnership and ongoing engagement with individual partners to ensure appropriate access and care pathways for people of all ages to be supported to stop smoking.

Promotional materials will be distributed widely by CGL to partners and the public in the coming weeks.

10. Bromley GP Alliance (BGPA)

Bromley GP Alliance (BGPA) Winter Illness Hubs

BGPA Winter Illness Hubs commenced Monday 11th November 2024, running until Tuesday 22nd April 2025.

This service provides same-day, face-to-face GP appointments which can be booked by GP practices via GP Connect. The sessions run from 4pm-8pm weekdays, and 1pm-5pm weekends.

From 11th November - 9th February, BGPA has provided 6,899 appointments, with 6,474 booked. Utilisation stands at 93% with 67 patients referred to UTC (1%). Unutilised slots are offered to 111 and UTC.

For the majority of this service, BGPA is providing 4 GP sessions on weekdays, operating at:

- Beckenham Clinic
- Crown Medical Centre
- Poverest Medical Centre
- Links Medical Practice – Mottingham

These appointments are for urgent same day issues and must adhere to the inclusion/exclusion criteria that has been circulated to practices.

If you have any questions regarding Winter Illness Hubs, please email: **alliancehub@nhs.net**

Bromleag Care Practice commended at London General Practice Awards

BGPA is thrilled to share that Bromleag Care Practice was Commended at the London General Practice Awards 2025, in the “Safety Award” category.

Dr Eleanor Jones and Dr Noim Amin, Co-Clinical Leads for Bromleag Care Practice: “We are absolutely thrilled and honoured to have been commended at the London General Practice Awards 2025 in the “Safety Award” category. This recognition reflects the dedication and hard work of our entire team in ensuring that patient safety is at the forefront of everything we do.

As Clinical Leads for Bromleag Care Practice, we are immensely proud of our commitment to creating a safe and supportive environment for both our patients and staff. This award is a

testament to the collaborative efforts, innovation, and attention to detail that go into our clinical practices. Safety is not just about protocols - it is about fostering a culture where our patients feel secure, heard, and well-cared for.

It is an ongoing journey, and we are excited to continue improving and building upon the high standards we have set across our Care Homes and Extra Care Housing.

We want to express our deepest gratitude to our dedicated team, and to all our patients for their trust and support. Together, we will continue to set the bar for safe, effective, and compassionate care."

Congratulations to the entire team!

ENCLOSURE: 7
AGENDA ITEM: 9

ONE BROMLEY
WORKING TOGETHER TO IMPROVE HEALTH AND CARE

One Bromley Local Care Partnership Board

DATE: Thursday 27th March 2025

Title	**Month 10 2024/25 SEL ICB Finance Report**	
This paper is for **information.**		

Executive Summary	• The SEL ICB financial allocation as at month 10 was £4,814,464k.
	• As at month 10 the SEL ICB is forecasting that it will deliver a year-end position of break-even.
	• In reporting the month 10 position, the ICB has delivered the following financial duties:
	  • Underspending (£1,724k YTD) against its management costs allocation, with the monthly cost of staff at risk being charged against programme costs in line with the relevant definitions.
	  • Delivering all targets under the Better Practice Payments code.
	  • Subject to the usual annual review, delivered its commitments under the Mental Health Investment Standard.
	  • Delivered the month-end cash position, well within the target cash balance.
	• The 2024/25 Bromley ICB/LCP place budget at month 10 was £261,754k.
	• The Bromley ICB/LCP place forecast outturn is break-even.	

Recommended action for the Committee	The Board is asked to NOTE the financial position.	
Potential Conflicts of Interest	N/A	
Impacts of this proposal	Key risks & mitigations	N/A
	Equality impact	N/A
	Financial impact	N/A

ONE BROMLEY
WORKING TOGETHER TO IMPROVE HEALTH AND CARE

Wider support for this proposal	Public Engagement	N/A
	Other Committee Discussion/ Internal Engagement	N/A
Author:	David Harris, Associate Director of Finance (Bromley), NHS South East London ICB	
Clinical lead:	N/A	
Executive sponsor:	David Maloney, Director of Corporate Finance, NHS South East London ICB	

NHS
South East London

One Bromley Local Care Partnership Board

27 March 2025

Month 10 2024/25, SEL ICB Finance Report

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1. Key Highlights

NHS South East London

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- The 2024/25 Bromley ICB/LCP place budget at month 10 was £261,754k.

- The Bromley ICB/LCP place forecast outturn is break-even.

2. Month 10 Bromley ICB/LCP Financial Position

NHS South East London

	Year to date Budget £'000s	Year to date Actual £'000s	Year to date Variance £'000s	ICB Budget £'000s	Forecast Outturn £'000s	Forecast Variance £'000s
Acute Services	6,591	6,432	159	7,909	7,718	191
Community Health Services	75,834	75,568	266	91,000	90,681	319
Mental Health Services	12,385	13,100	(715)	14,862	15,803	(941)
Continuing Care Services	22,607	23,141	(534)	27,128	27,706	(578)
Prescribing	42,705	42,534	171	51,047	50,512	535
Other Primary Care Services	1,917	1,917	0	2,301	2,301	(0)
Programme wide projects	-	-	0	-	(112)	112
Delegated Primary Care Services	48,118	48,118	0	64,027	64,027	(0)
Corporate Budgets	2,906	2,508	398	3,480	3,118	362
Total	**213,063**	**213,318**	**(255)**	**261,754**	**261,754**	**0**

- The borough is reporting an overspend of £255k at Month 10 and is forecasting a breakeven position at year end.
- The Community budget is £266k underspent year to date and the forecast underspend is £319k. This is due to some of the cost and volume contacts within the community directorate underperforming.
- The Mental Health budget is £715k overspent year to date and is forecasting an overspend of £941k. This is due to the cost per case budget being overspent due to an increase in client numbers. Cost per case clients are reviewed on a regular basis. A new high-cost client is included in the position this month and non-recurrent funding has been received to cover two-thirds of the cost. This represents a significant cost pressure of £900k next year.
- The Continuing Healthcare budget is £534k overspent year to date and the forecast is £578k overspent. The increase in adult CHC and FNC client numbers which is impacting adversely upon the position. There has been an increase in the number of care home providers in the borough which is putting pressure on the budget. The extra capacity in the borough will cause significant financial pressure, in addition to the current overspend, next year.
- The prescribing budget is £171k underspent year to date and is forecasting a £535k underspend at year end. This position represents an improvement in the forecast position compared to last month of £114k. Prescribing information (PPA) is received 2 months in arrears therefore this position is calculated using eight months of data.
- The Corporate budget is £398k underspent year to date due to vacancies and these are expected to be filled soon. The forecast position is £362k underspent as additional non-pay costs are anticipated due to the costs associated with Place Team moving into the new council offices in March 2025.
- The 2024/25 borough savings requirement is £6,426k. The borough is on track to achieve these savings and is reporting full delivery of the target.

3. Bromley ICB/LCP 2025/26 Budget Setting & CIP update

NHS South East London

- 2025/26 financial planning guidance has been received, and financial envelopes (budgets) have been issued. The start budget is set out below

Bromley	25/26 budget
	£000s
Acute Services	8,119
Community Health Services	93,470
Mental Health Services	11,251
Continuing Care Services	28,844
Prescribing	52,640
Other Primary Care Services	1,346
Other Programme Services	1,063
Delegated Primary Care Services	64,200
Corporate Budgets	1,655
Total	262,588

- Within this budget Bromley have received adjustments relating to the following: tariff inflation (£10.2m), tariff efficiency (£-5.0m), growth uplift (£4.3m) & convergence adjustment (£-1.3m). The net tariff uplift is therefore £5.2m and the net growth is £3.0m.

- The Continuing Healthcare budget (CHC) will form the biggest financial challenge to Bromley ICB/LCP in 2025/26, due to the additional capacity in the Borough. This will inevitably result in additional FNC (Funded Nursing Care) and CHC costs. There are also significant pressures within other areas including mental health and prescribing. Cost pressures total approximately £8.0m.

- The cost improvement plan (CIP) target for 2025/26 is 5% (£13.1m) and work is underway to identify schemes to deliver this target. After tariff efficiency and convergence are offset against this target £6.8m remains and schemes will be identified to deliver this target in full.

- 2025/26 budget setting is progressing well, and budget holder sign off and the submission of a fully developed CIP plan is expected to be achieved by the 28th March 2025 deadline.

Appendix 1

NHS
South East London

SEL ICB Finance Report

Month 10 2024/25

Contents

NHS South East London

1. Key Financial Indicators

NHS South East London

- The below table sets out the ICB's performance against its main financial duties on both a year to date (YTD) and forecast basis.
- As at month 10, the ICB is reporting a year to date (YTD) surplus of **£5,085k** against the revenue resource limit (RRL), which is **£5,164k** adverse to plan. The overspend relates to non-recurrent costs incurred by the ICB resulting from the Synnovis cyber-attack, specifically to review discarded tests and additional SMS messaging **(£765k)**, together with a planned change in financial positions with GSTT **(£4,399k),** net neutral to the ICS overall. The full year value of this change is **£13,198k**. Aside from the additional Synnovis expenditure, the ICB delivered in full the YTD element **(£4,142k)** of its additional savings requirement. **All boroughs are reporting that they will deliver a minimum of financial balance at the year end.**
- ICB is showing a YTD underspend of **£1,724k** against the running cost budget, which is largely due to vacancies within the ICB's staff establishment. These are in the process of being recruited to. The stranded costs (of staff at risk) following the MCR process to deliver 30% savings on administrative costs as per the NHSE directive, are being charged to programme costs in line with the definitions given for running costs versus programme costs.
- All other financial duties have been delivered for the year to month 10 period.
- As at month 10, and noting the risks outlined in this report, **the ICB is forecasting that it will deliver a year-end position of break-even, whilst noting the surplus of £33,321k included in the ICB plan on behalf of ICS partners.** More detail on the wider ICS financial position is set out the equivalent ICS Finance Report.

Key Indicator Performance

	Year to Date		Forecast		
	Target	Actual	Target	Actual	
	£'000s	£'000s	£'000s	£'000s	
Expenditure not to exceed income	3,978,866	3,984,030	4,775,506	4,775,506	
Operating Under Resource Revenue Limit	4,012,053	4,006,968	4,814,464	4,814,464	
Not to exceed Running Cost Allowance	30,570	28,846	35,938	35,938	
Month End Cash Position (expected to be below target)	4,750	3,036			
Operating under Capital Resource Limit	n/a	n/a	n/a	n/a	
95% of NHS creditor payments within 30 days	95.0%	100.0%			
95% of non-NHS creditor payments within 30 days	95.0%	99.0%			
Mental Health Investment Standard (Annual)			469,778	470,753	

2. Executive Summary

NHS South East London

- This report sets out the month 10 financial position of the ICB. The financial reporting is based upon the final June plan submission. This included a **planned surplus of £40,769k** for the ICB which has now been adjusted due to the impact of the deficit support funding by £1,800k, to give a revised surplus of **£38,969k.**
- The ICB's financial allocation as at month 10 is **£4,814,464k.** In month, the ICB has received an additional **£35,967k** of allocations. These are as detailed on the following slide.
- As at month 10, the ICB is reporting a year to date (YTD) overspend of **£5,164k** against the planned surplus of **£10,249k**. The overspend relates to non-recurrent costs incurred by the ICB resulting from the Synnovis cyber-attack, specifically to review discarded tests and additional SMS messaging **(£765k)** together with a planned change in financial positions with GSTT **(£4,399k),** net neutral to the ICS overall. Aside from the additional Synnovis expenditure, the ICB has delivered in full the YTD element **(£4,142k)** of its savings requirement.
- Due to the usual time lag in receiving current year information from the PPA, the ICB has received eight months of prescribing data, with an estimate made for the last two months. The ICB is reporting an overspend YTD of **£3,084k** at month 10. Details of the drivers and actions are set out later in the report.
- The current expenditure run-rate for continuing healthcare (CHC) services is above budget **(£2,540k YTD),** a small improvement from last month. Lewisham **(£2,956k),** Bromley **(£534k)** and Greenwich **(£154k)** boroughs are particularly impacted, with the other boroughs reporting small underspends.
- The ICB continues to incur the pay costs for staff at risk following the consultation process to deliver the required 30% reduction in management costs. The ICB's business case no longer requires DHSC approval and so the ICB has started the process of issuing notice to affected staff. This delay has generated additional costs for the ICB of **circa £4,624k YTD.** The first redundancy payments were made in December 2024, with the majority paid in January 2025.
- Only one place is reporting an overspend position YTD at month 9 **(Bromley, £255k),** which is a similar position to that reported last month. However, **a break-even position is being forecasted**. Financial focus meetings were held with all places and the CFO/Deputy CEO in December.
- In reporting this month 10 position, the ICB has delivered the following financial duties:
    - Underspending **(£1,724k YTD)** against its management costs allocation, with the monthly cost of staff at risk being charged against programme costs in line with the relevant definitions;
    - Delivering all targets under the **Better Practice Payments code**;
    - Subject to the usual annual review, delivered its commitments under the **Mental Health Investment Standard**; and
    - Delivered the **month-end cash position**, well within the target cash balance.
- As at month 10 the ICB is reporting a forecast break-even position against its plan for a **£38,969k** surplus, whilst noting the surplus of **£33,321k** included in the ICB plan on behalf of ICS partners. More detail on the wider ICS financial position is set out the equivalent ICS Finance Report.

3. Revenue Resource Limit (RRL)

NHS South East London

	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	South East London	Total SEL ICB
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
ICB Start Budget	**147,630**	**249,631**	**177,025**	**214,455**	**170,943**	**167,786**	**3,333,394**	**4,460,864**
M2 Internal Adjustments	1,049	3,464	2,037	2,146	901	2,431	(12,028)	-
M2 Allocations							11,975	**11,975**
M2 Budget	**148,679**	**253,095**	**179,062**	**216,601**	**171,844**	**170,217**	**3,333,341**	**4,472,839**
M3 Internal Adjustments	1,286	1,666	812	1,770	1,512	1,541	(8,587)	-
M3 Allocations				128			7,831	**7,959**
M3 Budget	**149,965**	**254,761**	**179,874**	**218,499**	**173,356**	**171,758**	**3,332,585**	**4,480,798**
M4 Internal Adjustments	33	33	125	128	120	128	(567)	-
M4 Allocations	106	177			75		17,952	**18,310**
M4 Budget	**150,104**	**254,971**	**180,000**	**218,627**	**173,551**	**171,886**	**3,349,969**	**4,499,108**
M5 Internal Adjustments	127	296	165	230	184	189	(1,191)	-
M5 Allocations						20	2,685	**2,705**
M5 Budget	**150,231**	**255,267**	**180,165**	**218,858**	**173,734**	**172,095**	**3,351,463**	**4,501,813**
M6 Internal Adjustments	578	290	804	1,021	660	891	(4,244)	-
M6 Allocations	1,137	1,635	1,489	2,124	1,694	1,756	110,442	**120,277**
M6 Budget	**151,946**	**257,191**	**182,459**	**222,003**	**176,088**	**174,741**	**3,457,662**	**4,622,090**
M7 Internal Adjustments	277	425	372	442	325	414	(2,256)	-
M7 Allocations	1,346	3,400	1,913	1,883	1,557	1,588	109,347	**121,034**
M7 Budget	**153,569**	**261,017**	**184,744**	**224,328**	**177,971**	**176,743**	**3,564,753**	**4,743,124**
M8 Internal Adjustments	243	158	240	531	149	425	(1,746)	-
M8 Allocations	110	114					31,516	**31,739**
M8 Budget	**153,922**	**261,288**	**184,983**	**224,860**	**178,120**	**177,168**	**3,594,523**	**4,774,864**
M9 Internal Adjustments	52	234	107	148	38	107	(687)	**0**
M9 Allocations							3,635	**3,634**
M9 Budgets	**153,973**	**261,521**	**185,090**	**225,009**	**178,158**	**177,275**	**3,597,471**	**4,778,497**
M10 Internal Adjustments								
Delegated Primary Care	70	97	91	125	98	102	(583)	-
Other minor movements	-	136	(2)	(21)	49	3	(165)	-
M10 Allocations								
ERF ICB overperformance M6&7	-	-	-	-	-	-	11,735	**11,735**
ERF ICB Programme holdback released M6&7	-	-	-	-	-	-	8,943	**8,943**
ERF ICB Delegated DOP holdback released M6&7	-	-	-	-	-	-	356	**356**
Month 10 depreciation adjustment	-	-	-	-	-	-	5,259	**5,259**
DDRB Uplift	-	-	-	-	-	-	3,711	**3,711**
Pension costs 9.4%	-	-	-	-	-	-	3,731	**3,731**
Pharmacy First	-	-	-	-	-	-	777	**777**
Various minor allocations	-	-	-	-	-	-	1,455	**1,455**
	-	-	-	-	-	-		-
M10 Budget	**154,043**	**261,754**	**185,179**	**225,113**	**178,305**	**177,380**	**3,632,690**	**4,814,464**

- The table sets out the Revenue Resource Limit (RRL) at month 10.
- The start allocation of **£4,460,864k** is consistent with the Operating Plan submissions.
- During month 10, internal adjustments were actioned to ensure allocations were aligned to the correct agreed budgets. These had no overall impact on the overall allocation. The main adjustments related to delegated primary care and the allocation of a residual balance and other smaller allocations, which were added to borough delegated budgets.
- In month, the ICB has received an additional **£35,967k** of allocations, giving the ICB a total allocation of **£4,814,464k** at month 10**.** The additional allocations received in month were in respect of ERF monies totalling **£21,034k**, depreciation funding for providers **£5,259k**, DDRB uplift **£3,711k**, pensions costs at 9.4% **£3,731k,** Pharmacy First **£777k** plus some smaller value allocations.
- Further allocations both recurrent and non-recurrent will be received as per normal throughout the year each month.

4. Budget Overview

NHS South East London

	M10 YTD							
	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	South East London	Total SEL CCG
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Year to Date Budget								
Acute Services	4,170	6,591	6,017	990	1,102	71	2,078,728	**2,097,668**
Community Health Services	18,806	75,834	32,604	23,525	24,453	30,228	219,527	**424,978**
Mental Health Services	8,883	12,385	7,160	19,305	6,413	8,547	449,363	**512,057**
Continuing Care Services	21,782	22,607	24,350	28,847	19,213	16,467	-	**133,266**
Prescribing	31,328	42,705	31,196	35,694	35,629	29,374	487	**206,413**
Other Primary Care Services	2,814	1,917	1,903	3,351	1,981	1,130	16,197	**29,294**
Other Programme Services	999	-	833	-	2,774	664	51,523	**56,793**
Programme Wide Projects	-	-	-	-	21	216	(10,053)	**(9,816)**
Delegated Primary Care Services	33,452	48,118	42,606	65,971	49,194	52,854	(2,633)	**289,562**
Delegated Primary Care Services DPO	-	-	-	-	-	-	181,909	**181,909**
Corporate Budgets - staff at Risk	-	-	-	-	-	-	-	-
Corporate Budgets	2,527	2,906	2,927	3,264	2,624	2,838	39,654	**56,741**
Total Year to Date Budget	**124,763**	**213,063**	**149,597**	**180,948**	**143,404**	**142,389**	**3,024,701**	**3,978,866**

	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	South East London	Total SEL CCG
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Year to Date Actual								
Acute Services	4,150	6,432	6,058	729	672	74	2,077,089	**2,095,205**
Community Health Services	18,548	75,568	31,853	23,597	23,127	29,410	221,169	**423,271**
Mental Health Services	8,829	13,100	7,881	19,704	6,412	9,647	449,246	**514,820**
Continuing Care Services	21,631	23,141	24,504	28,499	22,170	15,861	-	**135,806**
Prescribing	31,910	42,534	32,062	35,392	36,908	30,118	573	**209,497**
Other Primary Care Services	2,814	1,917	1,894	3,011	1,426	1,146	16,297	**28,506**
Other Programme Services	999	-	-	-	0	-	41,018	**42,018**
Programme Wide Projects	-	-	-	-	1,031	215	4,118	**5,364**
Delegated Primary Care Services	33,452	48,118	42,615	66,560	49,034	52,996	(2,633)	**290,142**
Delegated Primary Care Services DPO	-	-	-	-	-	-	182,525	**182,525**
Corporate Budgets - staff at Risk	-	-	-	-	-	-	4,624	**4,624**
Corporate Budgets	2,319	2,508	2,706	2,941	2,538	2,632	36,608	**52,252**
Total Year to Date Actual	**124,652**	**213,318**	**149,573**	**180,434**	**143,318**	**142,100**	**3,030,634**	**3,984,030**

	Bexley	Bromley	Greenwich	Lambeth	Lewisham	Southwark	South East London	Total SEL CCG
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Year to Date Variance								
Acute Services	20	159	(42)	261	430	(3)	1,639	**2,464**
Community Health Services	259	266	752	(72)	1,326	819	(1,641)	**1,707**
Mental Health Services	54	(715)	(721)	(399)	1	(1,100)	117	**(2,763)**
Continuing Care Services	151	(534)	(154)	348	(2,956)	606	-	**(2,540)**
Prescribing	(582)	171	(866)	303	(1,279)	(744)	(86)	**(3,084)**
Other Primary Care Services	(0)	0	8	340	555	(16)	(100)	**788**
Other Programme Services	0	-	833	-	2,774	664	10,504	**14,775**
Programme Wide Projects	-	-	-	-	(1,010)	0	(14,171)	**(15,180)**
Delegated Primary Care Services	-	-	(8)	(589)	160	(143)	-	**(580)**
Delegated Primary Care Services DPO	-	-	-	-	-	-	(616)	**(616)**
Corporate Budgets - staff at Risk	-	-	-	-	-	-	(4,624)	**(4,624)**
Corporate Budgets	209	398	221	323	86	207	3,046	**4,489**
Total Year to Date Variance	**111**	**(255)**	**24**	**513**	**86**	**289**	**(5,932)**	**(5,164)**

- **As at month 10, the ICB is reporting a year to date (YTD) surplus of £5,085k, which is £5,164k adverse to plan.** The explanation for this overspend against plan is as set out in the earlier slides. Aside from this additional Synnovis expenditure, the ICB has delivered in full the YTD element **(£4,142k)** of its savings requirement.
- Due to the usual time lag, the ICB has received eight months of prescribing data. Using an estimate for December and January based on prescribing days, the ICB is reporting an overall YTD overspend of **£3,084k**, although it should be noted that the position is differential across places. This is clearly a significant financial risk area as in previous years.
- The continuing care (CHC) financial position is **£2,540k** overspent which is a small improvement on last month. Lewisham continues to have the largest overspend **(£2,956)** which is predominantly driven by the full year effect of activity pressures seen in the second half of last year. **However, the run-rate in Lewisham has improved in-month**. Further details are included in this report.
- As described previously, the ICB is continuing to incur pay costs for staff at risk following the consultation process to deliver the required 30% reduction in management costs. The ICB's business case no longer requires DHSC approval and the ICB has issued notice and has now made most of the redundancy payments. The additional cost YTD is **£4,624k.**
- The MH/LD cost per case (CPC) budgets across the ICB are highlighting a cost pressure, with MH budgets reporting an overall overspend of **£2,763k,** a deterioration from last month. The CPC issue is differential across boroughs with Bromley, Greenwich, Lambeth and Southwark being the most impacted. ADHD and ASD assessments are a pressure in all boroughs.
- Only one place is overspending YTD at month 9 **– Bromley (£255k**), which is comparable with last month. **However, a break-even is forecast.** More detail regarding the individual place financial positions is provided later in this report.

5. Prescribing – Overview as at Month 10

NHS South East London

- The table below shows the month 10 prescribing position. Due to the usual lag in receiving information from the PPA, the ICB has received eight months of 2024/25 prescribing data. Based upon a prescribing days methodology to estimate spend for December and January, the ICB is reporting an overall YTD overspend on **PPA prescribing of £3,405k.**

M10 Prescribing	Total PMD (Excluding Cat M & NCSO)	Cat M & NCSO	Central Drugs	Flu Income	PY Flu (Benefit)/Cost Pressure	Adj and Cat M Clawback	Total 24/25 PPA Spend	M10 YTD Budget	YTD Variance - (over)/under	Annual Budget
	£	£	£	£	£	£	£	£	£	£
BEXLEY	30,838,954	213,608	1,030,553	(330,294)	3,336		31,756,158	31,125,767	(630,391)	37,205,018
BROMLEY	41,222,916	348,397	1,376,273	(517,895)	(31,432)		42,398,259	42,503,180	104,921	50,804,582
GREENWICH	30,848,882	261,747	1,031,294	(268,769)	(1,687)		31,871,466	30,954,249	(917,217)	37,000,001
LAMBETH	34,199,426	376,237	1,143,755	(304,058)	(23,696)		35,391,664	35,629,328	237,663	42,588,181
LEWISHAM	34,978,180	479,009	1,177,122	(219,804)	(6,642)		36,407,864	35,064,707	(1,343,157)	41,913,282
SOUTHWARK	28,825,984	351,140	968,673	(246,098)	(45,179)		29,854,519	29,073,631	(780,888)	34,752,075
SOUTH EAST LONDON						176,464	176,464	100,000.00	(76,464)	120,000
Grand Total	**200,914,342**	**2,030,137**	**6,727,669**	**(1,886,917)**	**(105,300)**	**176,464**	**207,856,395**	**204,450,861**	**(3,405,534)**	**244,383,139**

- This position is variable across the boroughs, with significant overspends in Lewisham, Greenwich and Southwark. Key drivers of the overspend continue to be Cat M and NCO price impacts, plus significant activity growth in medicines to support the management of long-term conditions. Other drivers of increased expenditure include increased prescribing of central nervous system drugs (especially ADHD drugs and migraine drugs), female sex hormones and nutrition and blood products. All these items are showing a higher % increase than is being seen nationally. The boroughs continue to reviewing how each of these issues has impacted them specifically.
- Lewisham place is seeing the largest cost pressure **(£1,343k YTD).** Actions being undertaken taken to address the position include the review of additional savings opportunities including the patent expiry on key drugs such as Rivaroxaban, and additionally drugs and other items which are recommended not to be prescribed in primary care are being reviewed to ensure they are not prescribed by practices. An audit has been undertaken of patients being managed under the Monitored Dosage System (MDS) and Medication Administration Records (MARS). This sets out a basis for ensuring that patients are reassessed as required on an annual basis and has been committed to by the Local Pharmaceutical Committee (LPC) and the Lewisham Medical Committee (LMC). Through ensuring an annual review of patient needs, recurrent savings against the annual budget of circa £626k are planned.
- Non PPA budgets are underspent by **£331k** giving an overall YTD overspend of **£3,084k,** a favourable movement of **£121k** in-month.

5. Prescribing – Comparison of 2425 v 2324

NHS South East London

- The table below compares April to November prescribing data for 2023 and 2024. The headlines are that expenditure in the ICB is increasing marginally faster **(2.3%)** than nationally **(2.0%)** and slower than the London average **(3.0%).** This is driven by a combination of the cost per item falling more slowly **(1.8%)**, together with a rise in activity **(4.2%)** albeit at a significantly slower rate than across London **(6.0%)**.

Prescribing
Comparison of April to November 2024 v 2023

	2023 April to November	2024 April to November	Change £	Change %
South East London ICB:				
Expenditure (£'000)	159,931	163,556	3,625	**2.3%**
Number of Items ('000)	17,042	17,756	714	**4.2%**
£/Item	9.38	9.21	-0.17	**-1.8%**
London ICBs:				
Expenditure (£'000)	812,568	836,864	24,296	**3.0%**
Number of Items ('000)	95,684	101,445	5,762	**6.0%**
£/Item	8.49	8.25	-0.24	**-2.9%**
All England ICBs:				
Expenditure (£'000)	6,722,381	6,859,524	137,143	**2.0%**
Number of Items ('000)	795,251	829,762	34,511	**4.3%**
£/Item	8.45	8.27	-0.19	**-2.2%**

- It is unrepresentative to base judgements solely on eight months of information, but the key factors explaining the SEL position include:
  - Increase in drugs activity and expenditure to support patients with long term conditions;
  - Increased prescribing of central nervous system drugs (especially ADHD drugs and migraine drugs), female sex hormones and nutrition and blood products. All these items continue to show a higher % increase than is being seen nationally;
  - Impact of NCSO remains a factor.

6. Dental, Optometry and Community Pharmacy

NHS South East London

- In April 2023, ophthalmic, community pharmacy and dental services were delegated to ICBs from NHS England. The table below sets out the financial position of these budgets on both a month 10 YTD and forecast basis.

Service	YTD Budget £'000s	YTD Actual £'000s	YTD Variance - (over)/under £'000s	Annual Budget £'000s	Forecast £'000s	FOT Variance - (over)/under £'000s
Delegated Primary Dental	89,125	86,511	2,614	106,950	103,813	3,137
Delegated Community Dental	6,413	6,413	(0)	7,696	7,696	0
Delegated Secondary Dental	46,581	46,581	(0)	55,553	55,553	(0)
Total Dental	**142,119**	**139,505**	**2,614**	**170,199**	**167,062**	**3,137**
Dental Ring Fence	138,935	138,935	0	166,722	166,722	0
Dental Non Ring Fence	3,184	570	2,614	3,477	340	3,137
Total Dental	**142,119**	**139,505**	**2,614**	**170,199**	**167,062**	**3,137**
Delegated Ophthalmic	12,920	14,877	(1,957)	15,504	17,941	(2,437)
Delegated Pharmacy	26,268	27,542	(1,274)	31,271	32,799	(1,528)
Delegated Property Costs	602	602	0	722	722	0
Total Delegated DOPs	**181,909**	**182,525**	**(616)**	**217,696**	**218,525**	**(828)**

a) Delegated Dental

- Overall, Dental is showing a YTD underspend against budget of £2,614k, and a forecast of £3,137k for the full year. The underspend is forecast to partially mitigate the overspends within Ophthalmic and Community Pharmacy. **The dental ringfence of £166,722k is expected to be delivered in 24/25, with full year expenditure forecast to be £167,062k.** Due to the volatility of dental activity the 2425 budget was set greater than the ringfenced value. The month 10 accrual is based December's dental report downloaded from the national e-Den system. The year-to-date level of dental activity is 73.3% and the forecast is 90.9%, with activity levels expected to pick up as the year progresses. The delegated property costs relate to where the primary care dentists are working either in NHS PS or CHP sites and rent is charged.

b) Delegated Ophthalmic

- The YTD position is an **overspend of £1,957k**. The spend largely relates to Optician Sight Tests and Vouchers submitted by high street opticians within the SEL geography regardless of where the patient resides – claims are based upon location of provider not client/patient. The claims are as per a national framework arrangement, under which the ICB has a requirement to pay.

c) Delegated Community Pharmacy

- The YTD position is an **overspend of £1,274k**, noting that information is received 2 months in arrears with an accrual then based upon the 8 months average using the number of Prescribing days. The overspend is driven by the costs associated with professional fees and advanced services. Pharmacy First will be fully funded by non-recurrent allocations from NHS England which are received in arrears.

7. NHS Continuing Healthcare

NHS South East London

Financial Position (Month 10): The overall Continuing Healthcare (CHC) financial position reflects a **£2,540k** overspend, showing a slight improvement of £130k from the previous month. Cost pressures vary across boroughs, with Lewisham, Bromley, and Greenwich reporting overspends, while the remaining three boroughs collectively underspending by approximately £1,104k.

Key Drivers of Overspend:

- **Lewisham:** the largest contributor to the overspend **(£2,956k),** primarily driven by the full-year impact of activity pressures from late last year (approximately £1,445k), particularly among Learning Disability (LD) clients. Actions taken to address this include:
    - Weekly meetings led by the Place Executive Lead to implement and monitor savings plans.
    - An ongoing review and cleansing of the client database, which has resulted in an improvement in the monthly run rate as of Month 10.
- **Bromley:** the overspend **(£534k)** is due to increased activity from expanded bed capacity, higher staff costs from new contracting arrangements, and settlements for retrospective cases. A review of these cases is ongoing to understand why Bromley appears to be an outlier, compared to other SEL boroughs.
- **Greenwich:** the overspend **(£154k)** can be attributed to an increase in activity in Funded Nursing Care and Joint Funded clients.
- **Other Boroughs:** are reporting improvements to financial positions, primarily due to ongoing service and client database reviews.

Provider Price Reviews: an ICB panel was established to review provider price increase requests exceeding 1.8%. The panel meets weekly to ensure consistency across SE London and mitigate significant cost increases. Boroughs initially budgeted for a 4% inflationary uplift. In Month 7, reserves were released where agreements were below budget, and this process will be repeated in Q4.

Savings Initiatives: all boroughs report progress on CHC savings plans, with three boroughs exceeding their targets. However, rising activity levels and higher-cost patients continue to exert financial pressures on the CHC budget.

8. Provider Position

NHS South East London

Overview:

- This is the most material area of ICB spend and relates to contractual expenditure with NHS and Non-NHS acute, community and mental health providers, much of which is within block contracts.

- In year, the ICB is forecasting to spend circa **£3,354,944k** of its total allocation on NHS block contracts, with payments to our local providers as follows:

    - Guys and St Thomas **£765,680k**
    - Kings College Hospital **£873,911k**
    - Lewisham and Greenwich **£688,344k**
    - South London and the Maudsley **£330,249k**
    - Oxleas **£255,436k**

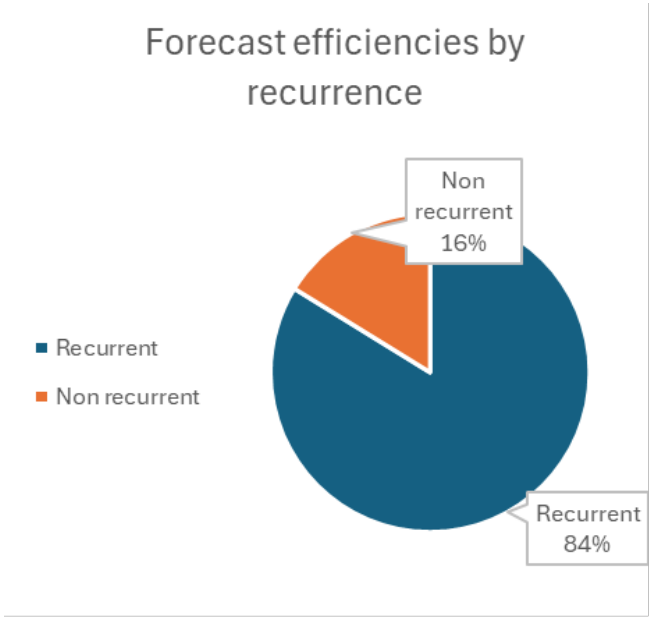
- In month, the ICB position is showing a break-even position on these NHS services and a break-even position has also been reflected as the forecast year-end position.

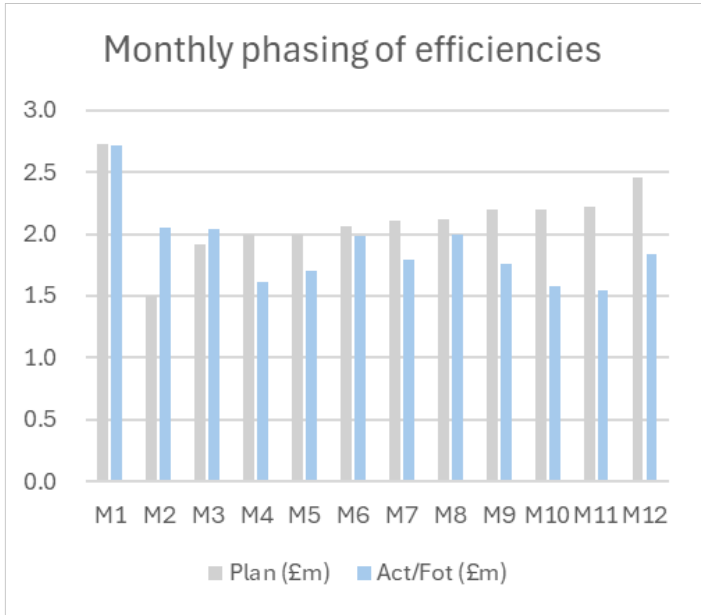
9. ICB Efficiency Schemes at as Month 10

NHS South East London

- The 6 places within the ICB have a total savings plan for 2024/25 of **£25.5m.** In common with the previous financial year, the key elements of the savings plans are in continuing healthcare (CHC) and prescribing.
- The table to the right sets out the YTD and forecast status of the ICB's efficiency scheme as at month 10.
- **As at month 10, overall, the ICB is reporting actual delivery of £24.4m, which is £5.8m ahead of plan.** At this stage in the financial year, the annual forecast is to exceed the efficiency plan **(by £3.6m),** although this will need ongoing close monitoring.
- The current risk rating of the efficiency plan is also reported. At this stage in the year, none of the forecast outturn of **£29.1m** has been assessed by the places as **high risk.**
- Most of the savings **(84%)** are forecast to be delivered on a recurrent basis.

	M9 year-to-date			Full-year 2024/25			Full Year - Identified			Full Year Forecast - Scheme Risk		
	Plan	Actual	Variance	Plan	Forecast	Variance	Plan	FOT	Change	Low	Medium	High
Providers	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Bexley	2.8	3.6	0.8	3.5	4.4	0.9	3.5	4.4	0.9	4.4	0.0	0.0
Bromley	4.4	5.1	0.7	6.3	6.4	0.1	6.3	6.4	0.1	4.2	2.2	0.0
Greenwich	2.5	3.8	1.2	3.5	4.6	1.1	3.5	4.6	1.1	2.6	2.0	0.0
Lambeth	3.8	5.6	1.8	5.2	6.1	0.9	5.2	6.1	0.9	2.2	3.9	0.0
Lewisham	2.4	3.0	0.6	3.2	3.6	0.4	3.2	3.6	0.4	2.9	0.7	0.0
Southwark	2.7	3.4	0.7	3.8	4.0	0.2	3.8	4.0	0.2	3.9	0.1	0.0
SEL ICB Total	18.6	24.4	5.8	25.5	29.1	3.6	25.5	29.1	3.6	20.2	8.9	0.0





10. Corporate Costs – Programme and Running Costs

Area		Year to Date		
	Annual Budget	Budget	Actual	Variance
	£	£	£	£
Boroughs				
Bexley	2,629,810	1,967,360	1,775,033	192,327
Bromley	3,314,269	2,494,952	2,038,414	456,539
Greenwich	3,221,499	2,428,123	2,250,499	177,624
Lambeth	3,737,440	2,704,196	2,417,766	286,430
Lewisham	2,930,436	2,200,827	2,120,486	80,341
Southwark	3,320,399	2,418,490	2,239,085	179,405
Subtotal	19,153,853	14,213,949	12,841,283	1,372,666
Central				
CESEL	461,544	384,619	234,997	149,622
Chief of Staff	3,141,259	2,617,717	2,384,632	233,085
Comms & Engagement	1,677,650	1,398,041	1,153,774	244,267
Digital	1,688,342	1,406,951	987,050	419,902
Digital - IM&T	3,163,430	2,636,190	2,527,261	108,930
Estates	649,177	540,980	620,899	(79,919)
Executive Team/GB	2,387,601	1,989,668	1,914,847	74,821
Finance	6,830,563	2,582,969	2,348,076	234,893
Staff at Risk Costs	0	-	4,621,944	(4,621,944)
London ICS Network	(1)	0	-	0
Medical Director - CCPL	1,604,413	1,335,511	1,063,678	271,833
Medical Director - ICS	271,387	226,155	192,039	34,116
Medicines Optimisation	4,353,888	3,628,238	2,974,690	653,548
Planning & Commissioning	8,402,233	7,001,858	6,264,658	737,200
Quality & Nursing	1,937,472	1,614,557	1,482,561	131,995
SEL Other	0	-	(258)	258
South East London	0	-	181,769	(181,769)
Subtotal	36,568,958	27,363,456	28,952,617	(1,589,161)
Grand Total	55,722,811	41,577,405	41,793,900	(216,495)

- The table shows the YTD month 10 position on programme and running cost corporate budgets.
- As described earlier in the report, the ICB is continuing to incur the pay costs for staff at risk following the consultation process to deliver the required 30% reduction in management costs.
- The process of issuing notices to at risk staff has largely been completed with most of redundancy payments now having been made. The delay has generated additional costs for the ICB both in respect of the ongoing cost **(circa £4,622k YTD)** together with the impact upon the final redundancy payments, given longer employment periods etc. The monthly costs should now see a significant reduction going forward. The actual redundancy costs are not included in this table as they have been charged against the provision made at the end of the last financial year.
- **Overall, the ICB is reporting an overall YTD underspend on its corporate costs of circa £216k,** a deterioration in-month, which is a result of vacant posts being recruited into.
- As highlighted in earlier slides, the ICB is **underspending (£1,724k YTD)** against its **management (running) costs** allocation.

11. Cash Position

NHS South East London

- The Maximum Cash Drawdown (MCD) as at month 10 was **£4,773,507k**. The MCD available as at month 10, after accounting for payments made on behalf of the ICB by the NHS Business Authority (largely relating to prescribing, community pharmacy and primary care dental expenditure) was **£819,568k**.
- As at month 10 the ICB had drawn-down 82.8% of the available cash compared to the budget cash figure of 83.3%. In month 10, the ICB did not need to request a supplementary cash drawdown. No supplementary cash drawdown has been requested for February 2025 either.
- The cash key performance indicator (KPI) has been achieved in all months so far this year, showing continued successful management of the cash position by the ICB's Finance team. The actual cash balance at the end of Month 10 was **£3,036k**, well within the target set by NHSE **(£4,750k). The ICB expects to utilise its cash limit in full by the year end.**
- ICBs are expected to pay 95% of all creditors within 30 days of the receipt of invoices. To date the ICB has met the BPPC targets each month, and it is expected that these targets will be met in full both each month and cumulatively at the end of the financial year.

ICB Annual Cash Drawdown Requirement for	2024/25 AP10 - JAN 25	2024/25 AP9 - DEC 24	2024/25 Month on month movement
	£000s	£000s	£000s
ICB ACDR	4,773,507	4,737,540	35,967
Capital allocation	0	0	0
Less:			
Cash drawn down	(3,638,000)	(3,258,000)	(380,000)
Prescription Pricing	(233,712)	(210,218)	(23,494)
HOT	(1,894)	(1,709)	(185)
POD	(76,645)	(69,137)	(7,508)
Pay Award charges			0
PCSE POD	43	43	0
Pension Uplift	(3,731)		(3,731)
Remaining Cash limi	**819,568**	**1,198,519**	**(378,952)**

Cash Drawdown	Monthly Main Draw down £000s	Supplementary Draw down £000s	Cumulative Draw down £000s	Proportion of ICB ACDR %	KPI - 1.25% or less of main drawdown £000s	Month end bank balance £000s	Percentage of cash balance to main draw
Apr-24	340,000	0	340,000	8.30%	4,250	3,101	0.91%
May-24	325,000	0	665,000	16.30%	4,063	237	0.07%
Jun-24	365,000	0	1,030,000	25.27%	4,563	3,114	0.85%
Jul-24	350,000	0	1,380,000	33.70%	4,375	2,608	0.75%
Aug-24	320,000	0	1,700,000	41.57%	4,000	661	0.21%
Sep-24	360,000	0	2,060,000	49.00%	4,500	3,744	1.04%
Oct-24	347,000	106,000	2,513,000	58.10%	4,338	3,419	0.99%
Nov-24	355,000	0	2,868,000	65.90%	4,438	224	0.06%
Dec-24	365,000	25,000	3,258,000	74.70%	4,563	3,286	0.90%
Jan-25	380,000	0	3,638,000	82.80%	4,750	3,036	0.80%
Feb-25	360,000		3,998,000		4,500		
Mar-25							
3,867,000	**131,000**						

12. Metrics Report

NHS South East London

- The ICB receives a metrics report from NHS England every month which is compiled from information from our ledger and nationally collated by SBS. **This ranks all ICBs against a set of national key financial metrics.**
- The report below relates to December 2024 as the January report will not be received until the end of February which is too late for this reporting cycle.
- In terms of performance, **SE London ICB has moved back to 1st in the country with an improved score from last time which is very positive.** The metric scores below shows that we now have 2 scores of the maximum 5, with all scores now above 3.
- Each score shown on this dashboard has several metrics sitting behind it, which relate to good financial practice. The ICB is currently scoring especially well in two areas (maximum scores of 5) which are a) Accounts Receivable, showing the work undertaken in this area to reduce and manage debt and b) GL and VAT where all balance sheet reconciliations are up to date with no dated reconciling items. The finance team are continuing to strive to improve the scores in the 3 other areas and this month further improvements have been delivered in Accounts Payable (non-NHS) and General Accounts.
- Further work is ongoing to establish how further improvements can be made.

Organisation Name	NHS South East London ICB			
Organisation Code	QKK		Period	Dec-24
Region	London		Peer Rank	1 / 42 ICB

	Oct-24	Nov-24	Dec-24	3 month average
Overall Score (max 25)	19.52	19.15	19.94	19.54

	Oct-24	Nov-24	Dec-24	3 month average
Accounts Payable - NHS	3.68	3.47	3.32	3.49
Accounts Payable - Non NHS	2.67	2.94	3.39	3.00
Accounts Receivable	4.94	4.59	5	4.84
General Accounts	3.23	3.15	3.23	3.20
GL and VAT	5	5	5	5.00

13. Mental Health Investment Standard (MHIS) – 2024/25

NHS South East London

Summary

- SEL ICB is required to deliver the Mental Health Investment Standard (MHIS) by increasing spend over 2023/24 outturn by a **minimum of the growth uplift of 6.85%, a target of £469,778k.** This spend is subject to annual independent review. The 2023/24 review is currently taking place.

- MHIS excludes:
  - spending on Learning Disabilities and Autism (LDA) and Dementia (Non MHIS eligible).
  - out of scope areas include ADHD and the physical health elements of continuing healthcare/S117 placements
  - Spend on Service Development Fund (SDF) and other non-recurrent allocations

- Slide 2 summarises the 2024/25 SEL ICB MHIS Plan. As at Month 10 we are forecasting MHIS delivery of **£470,753k**, exceeding the target by **£975k** (0.21%). This is largely made up of over-delivery against the plan on prescribing of approximately £1.9m, noting the potential volatility of prescribing spend based on the supply and cost of drugs. Slide 3 sets out the position by ICB budget area.

Risks

- We continue to see growth in mental health cost per case spend, in terms of client numbers, cost and complexity, for example on S117 placements. Actions to mitigate this include ensuring that timely client reviews are undertaken, reviewing and strengthening joint funding panel arrangements and developing new services and pathways.

- Learning disability placements costs continue to grow in some boroughs, with an increase in the complexity of care packages being seen. Mitigating actions include reviewing LD cost per case activity across health and care to understand care package costs, planning for future patient discharges to agree funding approaches and developing new services to prevent admissions.

- ADHD is outside the MHIS definition and is therefore excluded from this reported position. There is, however, significant and increasing independent sector spend on both ADHD and ASD services, with a forecast of £3.5m across a growing number of independent sector providers for Right to Choose referrals.

  The following actions are being taken:
  - increasing local provider capacity to reduce waiting times
  - working with local providers across adult and CYP ADHD services to review and transform care pathways to create sustainable services
  - undertaking an accreditation process to ensure the quality and VFM of independent sector providers.

13. Summary MHIS Position – Month 10 (January) 2024/25

NHS South East London

Mental Health Spend By Category	Category	Total Mental Health Plan 31/03/2025 Year Ending £'000	Mental Health - NHS Actual 31/01/2025 YTD £'000	Mental Health - Non-NHS Actual 31/01/2025 YTD £'000	Total Mental Health Actual 31/01/2025 YTD £'000	Mental Health - NHS Forecast 31/03/2025 Year Ending £'000	Mental Health - Non-NHS Forecast 31/03/2025 Year Ending £'000	Total Mental Health Forecast 31/03/2025 Year Ending £'000	Total Mental Health Variance 31/03/2025 Year Ending £'000
Children & Young People's Mental Health (excluding LD)	1	45,046	33,769	3,737	37,506	40,523	4,485	45,008	38
Children & Young People's Eating Disorders	2	2,841	2,368	0	2,368	2,841	0	2,841	0
Perinatal Mental Health (Community)	3	9,749	8,124	0	8,124	9,749	0	9,749	0
NHS Talking Therapies, for anxiety and depression	4	35,799	24,573	5,651	30,224	29,487	6,781	36,268	(469)
A and E and Ward Liaison mental health services (adult and older adult)	5	19,376	16,147	0	16,147	19,376	0	19,376	0
Early intervention in psychosis 'EIP' team (14 - 65yrs)	6	13,205	11,004	0	11,004	13,205	0	13,205	0
Adult community-based mental health crisis care (adult and older adult)	7	35,639	29,571	363	29,934	35,485	436	35,921	(282)
Ambulance response services	8	1,173	978	0	978	1,173	0	1,173	0
Community A – community services that are not bed-based / not placements	9a	122,258	92,543	8,311	100,854	111,051	9,974	121,025	1,233
Community B – supported housing services that fit in the community model, that are not delivered in hospitals	9b	25,758	12,419	8,344	20,763	14,902	10,044	24,946	812
Mental Health Placements in Hospitals	20	4,454	2,774	976	3,750	3,329	1,196	4,525	(71)
Mental Health Act	10	6,189	0	5,300	5,300	0	6,471	6,471	(282)
SMI Physical health checks	11	865	580	99	679	696	119	815	50
Suicide Prevention	12	0	0	0	0	0	0	0	0
Local NHS commissioned acute mental health and rehabilitation inpatient services (adult and older adult)	13	128,232	107,146	0	107,146	128,575	0	128,575	(343)
Adult and older adult acute mental health out of area placements	14	9,762	7,813	83	7,896	9,376	102	9,478	284
Sub-total MHIS (exc. CHC, prescribing, LD & dementia)		**460,346**	**349,809**	**32,864**	**382,673**	**419,768**	**39,608**	**459,376**	**970**
Mental health prescribing	16	9,190	0	9,239	9,239	0	11,087	11,087	(1,897)
Mental health in continuing care (CHC)	17	242	0	242	242	0	290	290	(48)
Sub-total - MHIS (inc CHC, Prescribing)		**469,778**	**349,809**	**42,345**	**392,154**	**419,768**	**50,985**	**470,753**	**(975)**
Learning Disability	18a	16,917	12,876	2,472	15,348	15,451	3,012	18,463	(1,546)
Autism	18b	3,837	2,431	86	2,517	2,917	105	3,022	815
Learning Disability & Autism - not separately identified	18c	48,399	4,025	38,994	43,019	4,830	46,936	51,766	(3,367)
Sub-total - LD&A (not included in MHIS)		**69,153**	**19,332**	**41,552**	**60,884**	**23,198**	**50,053**	**73,251**	**(4,098)**
Dementia	19	14,936	11,025	1,432	12,457	13,230	1,719	14,949	(13)
Sub-total - Dementia (not included in MHIS)		**14,936**	**11,025**	**1,432**	**12,457**	**13,230**	**1,719**	**14,949**	**(13)**
Total - Mental Health Services		**553,867**	**380,166**	**85,329**	**465,495**	**456,196**	**102,757**	**558,953**	**(5,086)**

ENCLOSURE: 8
AGENDA ITEM: 10

ONE BROMLEY
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One Bromley Local Care Partnership Board

DATE: Thursday 27 March 2025

Title	**Bromley Primary Care Group: March 2025 Report**
This paper is for **information**	
Executive Summary	The Bromley Primary Care Group (PCG) is responsible for decisions relating to the commissioning of primary medical services and to provide leadership and oversight for the delivery of high-quality services, strategic transformation and innovation in primary care across Bromley. The following items were considered at the March 2025 meeting of this group: **a) Capacity & Access Improvement Scheme delivery 24/25** PCG was advised on the £1.5m investment offered to Primary Care Networks (PCNs) to improve access through telephony, online and assessment at point of contact (triage). £475k of this funding is predicated on achieving the required standards. PCG noted that at the time of the report, only £144k of the achievement fund had been achieved by PCNs. There was encouragement from PCG members that PCNs take up the offer of help from the ICB and delivery partners in order to receive this investment, ahead of the window closing on 31 March. **b) Transition & Transformation Fund 24/25** This Fund offers a complementary funding stream to practices alongside the PCN funding. This scheme was designed to enable practices to invest in a change in working by consistently assessing all requests for appointments, thereby improving access through all forms of contact channels. This is described as the 'modern GP access model', also known as enhanced triage. NHS England's objective is to remove the '8am scramble' for appointments through this new way of working. PCG was assured that there had been very good progress across Bromley, with three-quarters of this funding already issued to practices as a result of their work to transition to a modern model of GP access. The remaining funding is to be released pending evidence of transition. Guidance is being offered to practices, with additional, tailored support to individual practices where needed, in order that all practices across Bromley can better provide a good model of access for their patients.

c) G84006: Catchment Area change request

PCG was briefed on the request to extend the Summercroft Surgery (G84006) practice catchment area. The Group was advised on the factors assessed as a contractual change to the practice. This included an outline of engagement of existing patients and those within the Primary Care Network PPGs, as well as Healthwatch. This has reported support for the proposed change. The change would benefit patients in terms of choice and provide greater resilience for the practice's long-term future.

The PCG endorsed the approval of the change to the practice catchment area and this will be implemented by the practice with the ICB's support.

d) **Group Consultations proposal**

PCG received a presentation outlining the evidence, benefits and opportunities afforded by introducing group consultations as part of primary care's model of service delivery.

Group Consultations are designed to support effective management of long-term conditions for a selected cohort of patients and has been demonstrated as effective and successful through evaluation from implementation in other parts of the country.

The report outlined the investment being offered by the ICB to introduce group consultations in a structured, phased way for suitable conditions, with expert training, clinical protocols and dedicated clinical resources to support a successful implementation. The project will be accompanied by an expert evaluation led by the Health Innovation Network to ensure this is adopted effectively and achieves the intended benefits for patients.

e) Pharmacy First briefing

PCG was updated on the progress with implementing the national Pharmacy First initiative in Bromley, noting the considerable use of this service by Bromley residents since its introduction in January 2024.

PCG was assured that proactive work was continuing by the ICB to further promote Pharmacy First across Bromley, to increase appropriate referrals and to address the technical issues encountered in the implementation. There will also be a Pharmacy First Champion project launched to further increase the number of referrals into the service and to ensure the service is a positive and effective experience for local residents.

	f) GP Appointments Data PCG was briefed on the GP Appointments Data (GPAD) national data set, which has been monitored by the ICB since it was introduced in October 2022. Analysis has indicated variation amongst Bromley in the metric monitoring the offer of appointments for eligible contacts within 14 days of initial contact. This variation has resulted in Bromley's average of appointments within 14 days at 84%, below the SEL average of 89%. The ICB is working with practices and PCNs to conduct a deeper dive into where there appears to be a longer wait for appointments, in order to determine how to best address the factors involved and ensure more patients are able to access an appointment according to their need within 14 days or less. **g) GP ARRS recruitment** PCG received a further update regarding the recruitment of GPs to the PCN Additional Roles Reimbursement Scheme (ARRS). PCG noted that six out of eight PCNs had successfully recruited to this role in 2024/25 and that the announcement of continued funding into 2025/26 should be expected to help recruitment in the final two PCNs.	
Recommended action for the Committee	The Local Care Partnership Board is asked to note: • The work undertaken by the Primary Care Group • The contractual decision to approve the extension of the catchment area for practice G84006 Summercroft Surgery • The approvals outlined in the report	
Potential Conflicts of Interest	Some members of the LCP and its sub-groups are providers of primary care services and would benefit from the decisions made at this meeting of PCG. Conflicts of interest were recorded and the decisions were deemed to have handled any potential conflicts of interest by the Chair.	
Impacts of this proposal	Key risks & mitigations	The Primary Care Group takes responsibility for assurance of primary care risk identification and mitigation on behalf of the One Bromley Local Care Partnership.
	Equality impact	The Primary Care Group will ensure the equality, diversity and inclusion objectives of One Bromley are considered in the course of its work.
	Financial impact	N/A
Wider support for this proposal	Public Engagement	Public engagement is being undertaken directly through the individual schemes and initiatives.

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	Other Committee Discussion/ Internal Engagement	N/A
Author:	Cheryl Rehal, Associate Director for Primary & Community Care, Bromley, NHS SEL ICB.	
Clinical lead:	Dr Andrew Parson, Co-Chair, One Bromley Local Care Partnership & GP Clinical Lead	
Executive sponsor:	Harvey Guntrip, Bromley Lay Member, NHS SEL ICB	

ENCLOSURE: 9

AGENDA ITEM: 11

ONE BROMLEY
WORKING TOGETHER TO IMPROVE HEALTH AND CARE

One Bromley Local Care Partnership Board

DATE: Thursday 27th March 2025

Title	**Bromley Procurement & Contracts Group – January / February 2025 Update**
This paper is for **information**	
Executive Summary	The Bromley Procurement & Contracts group supports the management and oversight of delegated budgets in terms of compliance with procurement and contract management requirement. The following items were discussed and agreed at the group's meetings on 23rd January and 19th February 2025. The next Bromley Procurement & Contracts group is scheduled for 19th March 2025. **Contract Award** • **Bromley Mental Health & Wellbeing Hub** – following a competitive tender process under Provider Selection Regime (PSR), the contract award report was received and the recommendations endorsed to award the contract to SEL MIND for a period of 5 years with the option to extend for a further 2 years. Contract documentation is being drafted for signature. • **Hospital Advocacy service at PRUH** – following evaluation of the single quote received, under the Public Contract Regulations 2015 (PCR) quotation process the group agreed to award a new contract to Advocacy First for a period of 1 year, commencing 1st April 2025 • **Rental of Beds and Mattresses** – following evaluation of quotes received under the PCR quotation process the group agreed to award a new contract to Inspire (incumbent provider) for a period of 1 year, commencing 1st April 2025. • **Bromley Digital Locum Bank Service (2025/27)** - following the evaluation of single required quote received under the PCR quotation process the group agreed to award a contract has been awarded to BETH for a period of 2 years, commencing 1st April 2025. **Contract Extensions** No contract extensions were enacted at either meeting. **Contract Variations** Contract variations in relation to National Tariff uplift 24/25 were noted for St Christopher's Hospice contracts, BHC Community Service and Vita Healthcare. **Procurements** The following updates were noted: -

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	• **Bromley Talking Therapies** - following a review of the completed PSR Direct Award C toolkit, the group agreed to award a new contract to the incumbent provider BHC. The relevant transparency notice is to be published. • **Community Headache Service -** following a review of the completed PSR Direct Award C toolkit, the group agreed to award a new contract to the incumbent provider BGPA for a period of 2 years with the option to extend for a further 1 year and a no fault termination period of 6 months, commencing 1st April 2025. The relevant transparency notice is to be published. • **Community Vasectomy Service -** following a review of the completed PSR Direct Award C toolkit, the group agreed to award a new contract to the incumbent provider BGPA for a period of 2 years with the option to extend for a further 1 year and a no fault termination period of 9 months, commencing 1st April 2025. The relevant transparency notice is to be published. • **Denosumab Service -** following a review of the completed PSR Most Suitable Provider (MSP) toolkit, the group agreed to award a new contract to the incumbent provider BGPA for a period of 3 years with the option to extend for a further 2 years and a no fault termination period of 9 months, commencing 1st April 2025. The relevant transparency notice is to be published. **<u>Other key areas of discussion to note</u>** • **Group Consultations** – A Memorandum of Understanding (MOU) has been produced between HIN (part of GSTT) and SEL ICB Bromley for the evaluation of PCN implementation of group consultations and training. • **Procurement Act 23** – on 24th February 2025 the Procurement Act 2023 came into force, which replaces the previous Public Contract Regulations 2015 (PCR) and relates to all non-health care services and goods. All Health Care related services continue to be in scope of Provider Selection Regime (PSR) and will need to comply with PSR regulations. • **Contracts Pipeline** - Contracts due to expire between March 24 – May 26 - The table in Appendix A indicates the commissioned services where the current contract is due to expire within the next 12 months and the potential procurement options for these services.
Recommended action for the Committee	The Committee is asked to note the work undertaken by the Procurement and Contracts group.
Potential Conflicts of Interest	Some of the organisations represented on the One Bromley Local Care Partnership are also providers working to the Integrated Care Board (ICB,) and will have current contracts with the ICB and will also be bidding for future contracts with the ICB. Care will need to be taken by both the Procurement and Contracts Group and this Board to identify and manage potential conflicts of interest in the procurement, award and monitoring of contracts.

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Impacts of this proposal	Key risks & mitigations	The Procurement and Contracts Group has an important role in identifying and managing risks on procurement and contracting issues on behalf of the One Bromley Local Care Partnership.
	Equality impact	The Procurement and Contracts Group has a role to play in supporting the delivery of One Bromley equality, diversity and inclusion objectives.
	Financial impact	The costs of running the Procurement and Contracts Group will be met within existing ICB budgets.
Wider support for this proposal	Public Engagement	N/A
	Other Committee Discussion/ Internal Engagement	N/A
Author:	Sean Rafferty, Director of Integrated Commissioning, SEL ICB / Asst Director for Integrated Commissioning, LBB	
Clinical lead:	Dr Andrew Parson, Co-Chair One Bromley Local Care Partnership	
Executive sponsor:	Dr Angela Bhan, Place Executive Lead	

ENCLOSURE: 9

AGENDA ITEM: 11

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Appendix A **Service**	**Current End Date**	**Type**	**Status**
Community Phlebotomy		Implied	Commissioners reviewing options
Community Denosumab		Implied	PSR MSP transparency notice to be issued
Cardiology Diagnostics		Implied	PSR Direct Award C transparency notice to be issued
IRIS Project Clinical Lead		Implied	Quote received under PCR – commissioner currently evaluating
Community Vasectomy No-scalpel technique		Implied	PSR Direct Award C transparency notice to be issued
Talking Therapies	31/03/2025	Active	PSR Direct Award C transparency notice issued
Hospice Consortia contract (Bromley, Lewisham, Lambeth, Southwark, Croydon) Palliative and end of life care services	31/03/2025	Active	SEL ICB agreed principle of PSR Direct Award A – awaiting confirmation from Croydon regarding inclusion on contract. Transparency notice to be issued.
Bromley Community Palliative services	31/03/2025	Active	Services to be included in Hospice Consortia Contract - separate spec and finance schedule
Headache Community Service	31/03/2025	Active	PSR Direct Award C transparency notice to be issued
Advocacy services	31/03/2025	Active	New contracted awarded until 30/3/26 under PCR quote process
Temporary service to establish additional, borough wide, same-day primary care capacity for winter illness	22/04/2025	Active	Non-recurrent contract
Cardiac Diagnostics & Exercise on Referral Programme	30/09/2025	Active	Service provision extended for a further 6 months whist options reviewed
Bromley Identification and Referral to Improve Safety (IRIS)	01/04/2026	Active	Options to be reviewed in 2025
Primary care enhanced services. Services: ADHD, DMARD, Phlebotomy, Gender Dysphoria, Gonadorelin, VMO, Safeguarding Adults and Children.	01/04/2026	Active	Options to be reviewed in 2025
GP Website	31/03/2026	Active	Options to be reviewed in 2025
Bromley Community Anticoagulation Service	31/05/2026	Active	Options to be reviewed in 2025

ENCLOSURE: 10
AGENDA ITEM: 12

ONE BROMLEY
WORKING TOGETHER TO IMPROVE HEALTH AND CARE

One Bromley Local Care Partnership Board

DATE: Thursday 27th March 2025

Title	**One Bromley Performance, Quality and Safeguarding Group: March 2025 Report**
This paper is for **information**	
Executive Summary	The meeting of the One Bromley Performance, Quality and Safeguarding Group held on the 27th February focussed on the development of Integrated Neighbourhood Teams (INTs), particularly from a performance, quality and safeguarding perspective. The group were appraised of the National Programme for INTs, and how it is aligned to the local One Bromley Strategy and the benefits envisaged for the local population, staff and patients. An INT is a group of health, social care and third sector colleagues working together locally to provide seamless, holistic care. Unlike traditional models, INTs focus on building ongoing relationships with residents, ensuring care is proactive, personalised and coordinated. It was noted that INTs do not need to include all of the features outlined below and that they can also include more: 1. Relational Care – Continuous, relationship-based care rather than episodic interactions. 2. Holistic Approach – Understands people's biopsychosocial needs together. 3. Proactive – Focuses on early identification, intervention, prevention and de-escalation. 4. Coordinated – Health, social and third sector service staff working together to meet people's needs. 5. Community – Centric – Involves and connects residents with local community resources. This approach links population understanding with personalised, efficient and preventative care. The proposed geography of the INTs was presented and the criteria used in selecting these. The PQS Group were asked to consider the following points in establishing the INTs: • Quality Management system needed and at what level

	• Continuous improvement • Performance measurement – flow through our system • Improving quality • Enhancing safeguarding Key issues raised were: • The importance of engagement with staff and the public in the development of INTs to tackle the challenges identified in local neighbourhoods. • Looking the impact on the patient journey of patient cohorts to consider the differences that would be made through these developments. • How INTs could support how long terms conditions, such as diabetes, could be managed in more co-ordinated way to encourage pro-active care and improve patient experience. • In developing INTs, as there is more integrated working, quality reporting, processes and safeguarding will need to be considered across organisations, with clearly defined roles and responsibilities. • There is a potential for INTs to pick up issues such as safeguarding or other concerns, with parties working collaboratively together and avoid silo working. • The focus on co-ordination and prevention would benefit all parties. • There would be opportunities to share existing examples of good practice, particularly in relation to cross-organisational working and working at scale, with support from partners. • Through the existing examples of integrated working in Bromley, there are examples where issues have arisen, and pragmatic solutions identified. However other issues and risks have which will need to be considered and monitored wider and solutions developed as INTs are established. • The roll out of PSIRF (Patient Safety Incident Response Framework) will be an opportunity and challenge for INTs where lessons can be learned from organisations where a framework is in place. • The role of a co-ordinator will be important in ensuring that INTs are effective in bring parties together to deliver care for patients. • A quality management system will be required to measure both the opportunities and benefits INTs can deliver as well as identifying and managing risks. • This will be a continuing discussion as the programme develops though the INT Development Group and will be brought back to a future PQS Meeting. <u>Bromley Place Quality Summary Report</u> The new Bromley place quality summary report was circulated to members of the group. It was agreed that CQC inspections and the

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	community equipment service, which were both highlighted in the report, be brought back to a future meeting <u>One Bromley Performance Report</u> The latest performance reports were circulated and noted. Updates were provided in respect of SMI (patients with serious mental illness) health checks. <u>Risk Register</u> This latest risk register was presented to the group with some risks reduced as we reach the year end, particularly in relation to finance. The risks are now being reviewed for 2025/26 with an update for the April meeting. <u>Safeguarding Update</u> An update was provided by the Safeguarding team, including on the impact of Right Care Right Person. This continues to be monitored, but no significant concerns have been raised to the safeguarding team. The tragic incidents in Nottingham and Southport have been discussed at the Bromley Community Safety Partnership Board and at the newly established Responsible Authority Group, including attendance by the Home Office. Safeguarding teams had been advised through national communications to continue to follow the current Prevent guidance in the meantime. A Joint Targeted Area Inspection (JTAI) took place in January. This was looking at the multi-agency response to the identification of initial risk of children and young people. The final report will be released and published in March, with an action plan to be put together by the end of June. The date of the next meeting is on 10th April 2025.	
Recommended action for the Committee	The One Bromley LCPB are asked to note this update	
Potential Conflicts of Interest	None	
Impacts of this proposal	Key risks & mitigations	Key risks are identified in all areas covered by the group and reviewed through the Bromley Borough risk management framework and risk register.

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	Equality impact	These are considered through the areas reported to the group with equality impact assessments completed where required.
	Financial impact	Not applicable
Wider support for this proposal	Public Engagement	Not applicable
	Other Committee Discussion/ Internal Engagement	Not applicable
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Appendix 1: Glossary of Terms

Acronyms and abbreviations	Term	Acronyms and abbreviations	Term
ACSC	Ambulatory Care Sensitive Conditions	JFP	Joint Forward Plan
ACP	Advance Care Plan	KPI	Key Performance Indicator
AHP	Allied Health Professional	KCH	Kings College Hospital
AHSN	Academic Health Science Network	LAS	London Ambulance Service
ASD	Autism Spectrum Disorder	LBB	London Borough of Bromley
AT	Assisted Technology	LCP	Local Care Partnership
AWOL	Absent Without Leave	LD	Learning Disability
BCF	Better Care Fund	LDAHC	Learning Disability Annual Health Check
B-CHIP	Bromley Children's Health Integrated Partnership	LGT	Lewisham & Greenwich (NHS) Trust
BGPA	Bromley General Practice Alliance	LMC	Local Medical Committees
BLG	Bromley, Lewisham and Greenwich (Mind)	LPC	Local Pharmaceutical Committee
BCP	Bromleag Care Practice	MDI	Metered Dose Inhalers
BSAB	Bromley Safeguarding Adults Board	MDT	Multi-Disciplinary Team
BTSE	Bromley Third Sector Enterprise	MASCC	Multinational Association of Supportive Care in Cancer
CAB	Citizens Advice Bromley	MHFA	Mental Health First Aiders
CAMHS	Child & Adolescent Mental Health Service	MHP	Mental Health Practitioners
CAS	Clinical Assessment Service	MRI	Magnetic Resonance Imaging
CC	Continuing Care	NCSO	No Cheaper Stock Obtainable
CCG	Clinical Commissioning Group	NICU	Neonatal Intensive Care Unit
CHC	Continuing Healthcare	NIHR	National Institute for Health and Care Research
CKD	Chronic Kidney Disease	NWCSP	National Wound Care Strategy Programme
COPD	Chronic Obstructive Pulmonary Disease	PEoLC	Palliative and End of Life Care
CPAG	Clinical & Professional Advisory Group	PPG	Patient Participant Group
CRM	Customer Relationship Management (system)	PREMS	Patient Reported Outcomes and Experiences Study
CYP	Children and Young Persons	PROFAIL	Patient Reported Outcomes for Frailty
DASS	Director of Adult Social Services	PROMS	Patient Reported Outcome Measures
DAWBA	Development and Well-Being Assessment	PCC	Palliative Care Congress
DES	Direct Enhanced Service	PCG	Primary Care Group (Bromley)
DM01	Diagnostics Waiting Times and Activity	PCN	Primary Care Network
DNA	Did Not Attend	PIP	Personal Independent Payment

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Appendix 1: Glossary of Terms

DSPT	Data Security & Protection Toolkit
DSCR	Digital Social Care Record
DTA/D2A	Discharge To Assess
EAPC	European Association for Palliative Care
ECH	Extra Care Housing
ED	Emergency Department
EHCP	Education, Health and Care Plan
ENT	Ear, Nose and Throat
FFT	Friends and Family Test
FY	Financial Year
GP	General Practice
GSTT	Guys and St Thomas' Hospital
H1	Half 1 (first 6 months of the financial year, April - September)
H2	Half 2 (last 6 months of the financial year, October - March)
H@H	Hospital at Home
HDU	High Dependency Unit
HIN	Health Improvement Network
HWBC	Health & Wellbeing Centre
iESE	Improvement and Efficiency Social Enterprise
IAPT	Improving Access to Psychological Therapies (Programme)
ICB	Integrated Care Board
ICP	Integrated Care Partnership
ICS	Integrated Care System
ILAG	Information, Advice and Guidance
INT	Integrated Neighbourhood Team
IPOS	Integrated Palliative Care Outcome Scale
IPU	Inpatient Unit
IF	Innovation Fund
IIF	Investment and Impact Fund
INR	International Normalised Ratio (INR) blood test
ITT	Invitation to Tender
IUEC	Integrated Urgent and Emergency Care
PPA	Prescription Pricing Authority
PR	Pulmonary Rehabilitation
PRUH	Princess Royal University Hospital
PSIS	Primary and Secondary Intervention Service
QOF	Quality and Outcomes framework
RCN	Royal College of Nursing
ROP	Referrals Optimisation Programme
RCPCH	Royal College of Paediatrics and Child Health
SEL	South East London
SELDOC	South East London Out of Hours Doctors Service
SCIE	Social Care Institute for Excellence
SDEC	Same Day Emergency Care
SLAM	South London and Maudsley
SPA	Single Point of Access
UCP	Universal Care Plan
UTC	Urgent Treatment Centre
VCS	Voluntary Community Sector
VCSE	Voluntary, Community & Social Enterprise
WCP	Winter Clinical Pathway