Report
ACH21-054

London Borough of Bromley

Decision Maker:	**HEALTH AND WELLBEING BOARD**
Date:	**25TH November 2021**
Decision Type:	Non-Urgent Non-Executive Non-Key
Title:	**Better Care Fund (BCF) and Improved Better Care Fund (iBCF) 21-22 Plan submission to NHS England**
Contact Officer:	Sean Rafferty, Assistant Director for Integrated Commissioning E-mail: sean.rafferty@bromley.gov.uk
Chief Officer:	Kim Carey, Interim Director of Adult Social Care, London Borough of Bromley Angela Bhan, Borough Director, South East London Clinical Commissioning Group
Ward:	All Wards

1. Summary

1.1 This report sets out the Bromley Better Care Fund Plan 2021-2022 for approval by the Board

2. Reason for the report going to Health and Wellbeing Board)

2.1 This report sets out the Bromley Better Care Fund 2021-22 Plan submitted to NHS England and seeks the Board's approval of the Plan.

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

3.1 To seek Health and Wellbeing Board approval for the submission of the BCF 21-22 Partnership Plan to NHS England.

Health & Wellbeing Strategy

1. Related priority: Not Applicable

Financial

1. Cost of proposal: BCF: £26,613k for 2021/22; iBCF: £7,503k in 2021/22

2. Ongoing costs: BCF: £26,613k (estimated); iBCF: £5,826k

3. Total savings: N/A

4. Budget host organisation: LBB

5. Source of funding: NHS South East London CCG, Department for Levelling Up, Housing and Communities (previously MHCLG)

6. Beneficiary/beneficiaries of any savings: London Borough of Bromley and NHS Seouth East London CCG (Bromley)

Supporting Public Health Outcome Indicator(s)

Not Applicable:

4. COMMENTARY

4.1 Policy Context

4.2 The Better Care Fund (BCF) programme supports local health and social care systems to successfully deliver the integration of health and social care in a way that supports person-centred care, sustainability and better outcomes for people and carers. The BCF encourages integration by requiring clinical commissioning groups (CCGs) and local authorities to enter into pooled budget arrangements and agree an integrated spending plan.

4.2 In support of BCF receipts from government all local areas are required to have a BCF Plan. The last Bromley BCF Plan was for the period 2019/2021 with the requirement to update plans in 2020 suspended because of the pandemic. Despite being past the mid-year point for the year we are required to submit a BCF Plan for 2021/22 as part of the assurance arrangements for receiving the BCF grant.

4.3 The BCF 2021-22 planning requirements, published on 30th September 2021, sets out requirements for implementing the government's Policy Framework for the Better Care Fund programme for this financial year. This framework sets out national conditions, metrics, and funding arrangements for the BCF programmes in 2021 to 2022. As the BCF is one of the governments national vehicles for driving health and social care integration, a key theme of local plans is the designing and delivery of integrated care across health and social care systems.

4.4 Local health and car commissioners are required to agree the alignment between their BCF plan and relevant Integrated Care Systems (ICS), with guidance set out on commissioning and delivery at system, place and neighbourhood levels and an ICS design framework, From April 2022, the expectation is that Integrated Care Boards (ICBs) and Integrated Care Partnerships (ICPs) will be created, with ICBs taking over the functions of CCGs.

4.5 The formal agreement of BCF plans rests with the Health and Wellbeing Board for each local area

4.6 Current Partnership Progress with delivery of BCF Metrics in Bromley in 2021.

4.7 The partnership continues to deliver activity and outcomes in line with anticipated metric outcomes as set out in the BCF plan for 20-21 and Q1 and Q2 of 21-22. The BCF plan for submission however requires the partnership to report on two new metrics for Q3 and Q4 based on historical performance on these new metrics and the cessation of measuring (for the purposes of the BCF report) 2 old metrics. A description of this change is detailed below.

4.8 BCF Planning Requirements for 21-22

4.9 Final BCF plans are to consist of a narrative plan of 15 to 20 pages that sets out the approach locally to:

a. Continue to implement a joined-up approach to integrated, person centred services across health, care, housing and wider public services locally. This should include a brief narrative on the high-level approach to aligning BCF plans with wider activity.

b. Support people to remain independent at home, including strengths-based approaches and how BCF funding will be used to support this.

c. Have improving outcomes for people being discharged from hospital.

d. Have a jointly approved planning template, including Income, Expenditure Ambitions for the BCF, national metrics, and plans for achieving these

4.10 Due to ongoing system pressures, there have been minimal changes to national conditions. In terms of BCF metrics, 21-22 planning requirements include changes to system metric description as detailed below:

20-21 Metrics	**21-22 Metrics**
Reduction in Non -Elective admissions This measure is now ended	The revised metric is now to measure Avoidable admissions
Reduction in delayed transfers of care This measure is now ended	Percentage of inpatients who have been in hospital for longer than 14 days and 21 days.
Reduction in admission to residential homes	Reduction in admission to residential homes
Number of people still at home following discharge from reablement services	Number of people still at home following discharge from reablement services
	Discharged to normal place of residence

5. The Better Care Fund Plan 2021-2022

5.1 The draft Better Care Fund Plan 2021-2022 is attached as an appendix to this report.

5.2 With the approval of the Chair of the Health and Wellbeing Board and Portfolio Holder for Adult Care and Health agreed jointly with the Chief Executive of South East London CCG this draft was submitted to NHS England in time to meet the deadline on 16 November 2021. The BCF guidance allows for an arrangement whereby the Plan may be submitted to NHS England in advance of the formal approval of the local Health and Wellbeing Board.

5.3 The draft Plan summarises the local joined-up approach to integrated, person centred services across health, care, housing and wider public services in Bromley and has carefully followed the NHS England provided template and guidance for its completion. Included in the submission.

5.4 The complete Plan is attached as an appendix to this report. A executive summary is given below.

6. Bromley BCF Plan 2021-2022 Executive Summary

6.1 The Bromley BCF priorities for 2021/22 have been informed by lessons learnt across the local health and care system during the response to waves one and two of the Covid pandemic. These local priorities are replicated in the Bromley Winter Resilience Plan for 2021/22 and based on the following five pillars:

a) *Increasing system capacity* – through additional workforce, capacity and services
b) *Data sharing and escalation* – sharing data and intelligence through multi-agency and multi-professional working with simple arrangements for escalation

c) *Single Point of Access and Discharge Arrangements* – integrated hospital triage and discharge pathways supported by a range of community-based health and care services
d) *Admissions avoidance* – through responsive urgent community response services and integrated working of community and acute clinicians proactively supporting patients with frailty, long term conditions or at high risk of needing hospital-based care
e) *Communications and engagement* – Localising national public health messages with advice and support targeted at residents, carers and health and care professionals

6.2 Since April 2020 local arrangements have been supported through a new Integrated Commissioning Service bringing together in one joined-up Local Authority and CCG team the commissioning of all out of hospital community-based services.

6.3 A strengths-based approach with a focus on preventative and early intervention services targets those most at risk of health inequalities and seeks to help people to remain living in their own homes wherever feasible.

6.4 Hospital discharge and reduced length of stay in hospital is better enabled through the Bromley Discharge Partnership arrangements incorporating multi-agency integrated triage and integrated pathways into the community and support to care homes and supported housing options. The Partnership received the top industry Municipal Journal Achievement Award for integrated health and care working in September 2021.

6.5 An array of clinical, therapy and other services seek to avoid the need for people to go to hospital and support safe and early discharge home.

6.6 Across health inequalities measures the population of Bromley perform similar if not better than the London and England average in all performance indicators for both males and females. Like in many other parts of the UK, Covid has had a disproportionate effect on some Bromley communities and our new Covid JSNA chapter will support our priorities for tackling health inequalities in our BCF Plan in 2022

6.7 Key changes since the Bromley BCF Plan in 2019 are:

a) Governance – health, care housing and voluntary sector partnership and governance arrangements have evolved towards ICS Local Care Partnership arrangements
b) Commissioning integration and collaboration– LB Bromley and SELCCG (Bromley) have implemented an Integrated Commissioning Service
c) One Bromley Discharge Partnership – Innovative Single Point of Access triage and care pathways introduced in wave 1 of the Covid pandemic have transformed inter-agency discharge arrangements
d) Enhancements to primary and secondary intervention provision – the recommissioning of services is updated and enhanced including additional support to self-funding residents
e) Assistive Technology – Funding has been allocated in 2021 to develop a series of assisted technology pilot schemes
f) Community equipment – Funding has been allocated in 2021 for a review of integrated community equipment arrangements. The aim is to review our current provision in this area to support budget planning and provide assurance regarding the spend and its benefits to the community.
g) Integrated approach to supporting care homes – integrated commissioning, market development, support and relationship management providing targeted and wrap around support to the local care home market.

7. IMPACT ON VULNERABLE PEOPLE AND CHILDREN

7.1 All services are designed to avoid people who are vulnerable reaching the point of crisis where they would be seeking support of statutory services and/or requiring unplanned admission.

7.2 The Improved Better Care Fund is for investment into adult services and will have a positive impact on vulnerable people through investment into safeguarding and adult social care.

8. FINANCIAL IMPLICATIONS

8.1 The 2021/22 budget for the Better Care Fund (BCF), including Disabled Facities Grant (DFG) and the Improved Better Care Fund (iBCF) is detailed in the tables below:

Commissioner	Scheme Type	Scheme Name	2021/22 budget
BCF Minimum CCG Contribution			
CCG	Assistive Technologies and Equipment	Assistive Technologies	563
LBB	Assistive Technologies and Equipment	Assistive Technologies	444
CCG	Bed based intermediate Care Services	Intermediate Care Services	1,337
LBB	Bed based intermediate Care Services	Intermediate Care Services	1,237
CCG	Carers Services	Support for carers	554
CCG	Community Based Schemes	Risk pool	1,416
Joint	Enablers for Integration	Community and Social Care Development Fund	1,063
LBB	Enablers for Integration	BCF Post	40
LBB	Enablers for Integration	Learning Disabilities	25
CCG	High Impact Change Model for Managing Transfer of Care	Risk pool	593
LBB	High Impact Change Model for Managing Transfer of Care	Risk pool	52
CCG	Home Care or Domiciliary Care	Improving healthcare services to Care Homes	330
LBB	Housing Related Schemes	Improving healthcare services to Care Homes	439
CCG	Integrated Care Planning and Navigation	Assistive Technologies	397
LBB	Integrated Care Planning and Navigation	Assistive Technologies	56
CCG	Personalised Care at Home	Personalised Support/care at home	652
CCG	Personalised Care at Home	Reablement services	1,000
LBB	Personalised Care at Home	Protecting Social Care	10,980
LBB	Prevention / Early Intervention	Support for carers/assistive technology	1,766
LBB	Reablement in a persons own home	Reablement services	1,227
			24,171
DFG			
LBB	DFG Related Schemes	Disabled Facilities Grants	2,443
			2,443
iBCF			
LBB	Assistive Technologies and Equipment	Equipment	214
CCG	Enablers for Integration	D2A staffing	95
LBB	Home Care or Domiciliary Care	D2A DomCare	321
LBB	Home Care or Domiciliary Care	DomCare	72
LBB	Home Care or Domiciliary Care	Whole system reserve	1,677
LBB	Personalised Budgeting and Commissioning	Reducing pressures	4,636
LBB	Residential Placements	D2A Placements	83
LBB	Residential Placements	Placements	405
			7,503
Grand Total			**34,117**

8.2 Funding for the BCF is from NHS South East London CCG (£24,171k) and the Department for Levelling Up, Housing and Communities (£7,503k for iBCF and £2,443k for DFG).

9. LEGAL IMPLICATIONS

9.1 The Care Act 2014 amended the NHS Act 2006 to provide the legislative basis for the Better Care Fund. It provides the mandate to NHS England to include specific requirements relating to the establishment and use of an integration fund. NHS England and the Government allocate the Better Care Fund to local areas based on a framework agreed with Ministers.

9.2 The amended NHS Act 2006 gives NHS England the powers to attach conditions to the payment of the Better Care Fund. For 2017-19 NHS England set the following conditions to access the CCG element of the funding:

- The requirement that the Better Care Fund is transferred into one or more pooled funds established under Section 75 of the NHS Act 2006.
- The requirement that Health & Wellbeing Boards jointly agree plans for how the money will be spent with plans signed off by the relevant local authority and clinical commissioning group(s).

9.3 Under the amended NHS Act 2006, NHS England has the ability to withhold, recover or direct the use of CCG funding where conditions attached to the BCF are not met, except for those amounts paid directly to local government.

9.4 For 2017-19, NHS England require that BCF plans demonstrate how the area will meet the following national conditions:

- Plans to be jointly agreed;
- NHS contribution to adult social care is maintained in line with inflation;
- Agreement to invest in NHS commissioned out-of-hospital services, which may include 7 day services and adult social care; and
- Managing Transfers of Care

9.5 The Improved Better Care Fund Grant determination is made by the Secretary of State under section 31 of the Local Government Act 2003. The grant may be used only for the purposes of meeting adult social care needs; reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready and ensuring that the local social care provider market is supported.

9.6 The Council is required to:

- Pool the grant funding into the local Better Care Fund, unless the authority has written ministerial exemption
- Work with the relevant Clinical Commissioning Group and providers to meet National Condition 4 (Managing Transfers of Care) in the Integration and Better Care Fund Policy Framework and Planning Requirements 2017-19 (revised 2019-20)
- Provide quarterly reports as required by the Secretary of State

Non-Applicable Sections:	Procurement Implications
Background Documents:	BCF Narrattive Plan Template 2021-2022 – NHS England

APPENDIX

BROMLEY BETTER CARE FUND PLAN 2021/22
Introduction

The joined-up approach to integrated, person centred services across health, care, housing and wider public services in Bromley is led by the *One Bromley* health and care partnership and commissioned through the LB Bromley and South East London CCG (Bromley) integrated commissioning arrangements.

Organisations involved in preparing and delivering on the Bromley BCF plan for 2021/22 are:

- London Borough of Bromley
- South East London CCG
- Kings College Hospital NHS Foundation Trust
- Bromley Healthcare (community health services provider)
- Oxleas NHS Foundation Trust
- St Christopher's Hospice
- Bromley Third Sector Enterprise (VCS consortium)
- Bromley GP Alliance
- Bromley Primary Care Networks (X 8)

The 2020/21 BCF Plan is an outcome of sustained collaborative work from across the One Bromley partnership agencies to support people to remain independent at home, and to jointly improve outcomes for people being discharged from hospital. Work on the local health and care objectives is developed, agreed and overseen through the One Bromley partnership governance arrangements. The partnership is in the process of finalising its Local Care Partnership arrangements as part of the place-based governance arrangements for the South East London ICS taking effect in 2022.

Executive Summary

The Bromley BCF priorities for 2021/22 have been informed by lessons learnt across the local health and care system during the local response to waves one and two of the Covid pandemic. These local priorities are replicated in the Bromley Winter Resilience Plan for 2021/22 and based on the following five pillars:

1. *Increasing system capacity* – through additional workforce, capacity and services
2. *Data sharing and escalation* – sharing data and intelligence through multi-agency and multi-professional working with simple arrangements for escalation
3. *Single Point of Access and Discharge Arrangements* – integrated hospital triage and discharge pathways supported by a range of community-based health and care services
4. *Admissions avoidance* – through responsive urgent community response services and integrated working of community and acute clinicians proactively supporting patients with frailty, long term conditions or at high risk of needing hospital-based care
5. *Communications and engagement* – Localising national public health messages with advice and support targeted at residents, carers and health and care professionals

Since April 2020 local arrangements have been supported through a new Integrated Commissioning Service bringing together in one joined-up Local Authority and CCG team the commissioning of all out of hospital community-based services.

A strengths-based approach with a focus on preventative and early intervention services targets those most at risk of health inequalities and seeks to help people to remain living in their own homes wherever feasible.

Hospital discharge and reduced length of stay in hospital is better enabled through the Bromley Discharge Partnership arrangements incorporating multi-agency integrated triage and integrated pathways into the community and support to care homes and supported housing options. The Partnership received the top industry Municipal Journal Achievement Award for integrated health and care working in September 2021.

An array of clinical, therapy and other services seek to avoid the need for people to go to hospital and support safe and early discharge home.

Across health inequalities measures the population of Bromley perform similar if not better than the London and England average in all performance indicators for both males and females.

Like in many other parts of the UK, Covid has had a disproportionate effect on some Bromley communities and our new Covid JSNA chapter will support our priorities for tackling health inequalities in our BCF Plan in 2022

Key changes since the Bromley BCF Plan in 2019 are:

- **Governance** – health, care housing and voluntary sector partnership and governance arrangements have evolved towards ICS Local Care Partnership arrangements
- **Commissioning integration and collaboration**– LB Bromley and SELCCG (Bromley) have implemented an Integrated Commissioning Service
- **One Bromley Discharge Partnership –** Innovative Single Point of Access triage and care pathways introduced in wave 1 of the Covid pandemic have transformed inter-agency discharge arrangements
- **Enhancements to primary and secondary intervention provision –** the recommissioning of services is updated and enhanced including additional support to self-funding residents
- **Assistive Technology –** Funding has been allocated in 2021 to develop a series of assisted technology pilot schemes
- **Community equipment** – Funding has been allocated in 2021 for a review of integrated community equipment arrangements. The aim is to review our current provision in this area to support budget planning and provide assurance regarding the spend and its benefits to the community.
- **Integrated approach to supporting care homes –** integrated commissioning, market development, support and relationship management providing targeted and wrap around support to the local care home market.

Better Care Fund Governance

The BCF budget is held by the Director of Adult Social Services and managed by the Integrated Commissioning Service. Officer oversight on the Fund and its schemes and programmes is given through an Integrated Commissioning Board jointly chaired by the Director of Adult Social Service and CCG Borough Director. The monitoring of progress on meeting BCF objectives and BCF spend is a standing item at a bi-monthly meeting of the Board.

The Local Authority Health & Wellbeing Board receives, at each quarter, a report on BCF activity, spend and performance.

Performance on health and care integrated working including BCF objectives is reported to the Local Authority's Health & Wellbeing Board, Health Overview and Scrutiny Committee (HoSC) and Adult Social Care Policy, Development and Scrutiny Committee.

Within SELCCG (Bromley) BCF progress is reported at the Bromley Clinical Strategy Group chaired by the Clinical Lead.

Oversight to hospital discharge and joint working arrangements is given by the One Bromley Executive (Local Care Partnership) chaired by the Site Chief Executive from the Princess Royal University Hospital and the Accident & Emergency Delivery Board chaired by the CCG Borough Director.

Leadership across Bromley health and care arrangements is given through the Bromley Borough Based Board, jointly chaired by the Council Leader and CCG Clinical Lead GP.

Overall approach to integration

Joint Priorities for 2021/2022

The Bromley BCF joint priorities for 2021/22 have been informed by lessons learnt across the local health and care system during the local response to waves one and two of the Covid19 pandemic. These local priorities are replicated in the Bromley Winter Resilience Plan for 2021/22 and based on the following five pillars:

Pillar 1: Increasing system capacity

System capacity is increased through LBB and NHS investment in:

- *Additional Workforce* - including Rapid Response Advance Nurse Practitioners (ANPs,) Rapid Access to Therapy therapists, adult social care - Care Managers, brokerage and Moving and Handling Risk Assessors
- *Additional Service Capacity* **-** including primary care hub appointments and UTC Christmas and new year cover, short term enhanced domiciliary care at home offer, block funded domiciliary care through January and access to rapid assisted technology fitting
- *New capacity in 2021/22 includes:*
  - Piloting increased access for children to primary care hub appointments
  - Increasing nurse capacity in UTC
  - Contingency for 7 day working and responding to activity surges

Pillar 2: Data sharing and escalation

Collating and sharing intelligence across the health and care system in 2021/22 includes:

- Implementing a data dashboard that notifies of system trends and pressures
- Mobilising the weekly Clinical and Professional Advisory Group - Clinical monitoring meeting to share the current clinical pressures and information that will help the system to respond initiating wider practice or capacity discussions where required including primary care, UTC, acute, community clinicians, 111 and London Ambulance Service
- Responding to extreme pressures through a system escalation call
- Having a robust plan in place for the peak period in Winter for how capacity will be maximised to respond to urgent and unplanned care pressures

Pillar 3: Single Point of Access and Discharge Arrangements

The following new services introduced in 2020 through Winter and covid funding will continue to play a key role in responding to 21/22 pressure management:

- Bromley Single Point of Access (SPA) and Discharge Partnership
- Bromley Rapid Access to Therapies (RATT)
- Hospital @Home for children and young people
- Bromley Community Covid Management Service and long covid clinics

The Demand and Capacity Meeting, established during winter 20/21 will continue to maintain system oversight of pathways and capacity, ensuring sufficient access to resources. This includes proactive management of the domiciliary and care home market.

New services to be introduced in 2021/22 include:
- Developing a community in-reach offer to pull patients from hospital to reduce inpatient length of stay
- Developing an Enhanced Community IV/AB short course offer to enable early supported discharge

Pillar 4: Admissions avoidance

Established services dedicated to delivering the urgent community response include Rapid Response (2 hr) and Rapid Access to Therapies (RATT). LBB OT services work with individuals with complex needs to support informal carers to maintain them at home avoid social admission to hospital.
Building on the successes of 2020/2021 we will maintain the integrated working of community and acute clinicians during the pandemic to enable care home residents to access specialist treatment in their place of residence when hospital admission is not in their best interest.
New provisions in 2021/2021 include:
- Building upon the experience of the Princess Royal University Hospital and community partners working together on the ONE Bromley respiratory pathway and Community Covid Management Service to create a Hospital @ Home offer - Urgent Respiratory Service and community IV/AB service for direct GP referrals
- Developing a front door admission avoidance model focusing on preventing social admissions.
- Mobilising the Clinical Professional Advisory Group (CPAG) to maintain oversight and react to the anticipated surge in viruses amongst adults and children, as predicted by Public Health

Pillar 5: Communications and engagement

Building on effective communications arrangements in previous years and developed during in the responding to the pandemic in 2020/21 there will be a continued focus on:
- Localising national campaigns and public facing information and advice on what services to use when
- Continuing integrated advice to care homes and care settings to care for their clients/residents
- Establishing an accessible ‘Winter Services Directory’ for all system partners and professionals

In addition, for 2021/2022 we are:

- Expanding the successful flu campaign to also promote Covid19 Boosters (in line with anticipated guidance)
- Embedding a routine method of communicating system wider UEC pressures, trends and emerging themes as well as information on additional winter capacity or resource
- Mobilising a ‘together through winter’ campaign to harness the joint working and commitment that underpinned the success of the response ot the Covid19 pandemic

Integrated Health and Care Commissioning

In April 2020 the Council and CCG established an Integrated Commissioning Service with an Assistant Director of Integrated Commissioning appointed as a joint postholder across the CCG and Local Authority. All out of hospital health and care services in Bromley are commissioned by this service. A section 75 agreement details specific integrated commissioning and service arrangements. BCF investment is used to develop health and care integration in several ways.

- Reablement – providing additional capacity to help people regain the skills they need to live independently after time in hospital or to remain independent in the community. Further service development is planned to create senior support workers in a trusted assessor role to provide low level equipment and provide a robust management structure to the service.
- Intermediate Care – to provide extra services to help people to leave hospital in a timely manner
- Winter Pressures – to prevent admission to and support timely discharge from hospital during the winter to relieve pressure on hospital beds
- Health Support to Extra Care Housing & Care Homes – providing additional support to people living in these locations
- Dementia Hub – to increase diagnosis and universal post diagnosis support
- Community Equipment – to support discharge from hospital and enable people to remain independent and safe at home for longer. To reduce and delay the need for care.
- Self-Management & Intervention (Bromley Well) – to focus on prevention and self-management of people with long term conditions and avert avoidable admissions and long-term care packages.

Achievements include:

- *Support for Integrated Care Networks (ICNs)* – The care is delivered by a multi-disciplinary team designed to help patients with the most complex care needs to stay well, remain independent and stay out of hospital where possible. ICNs have continued to have a positive impact in enabling people to stay at home and facilitated multi-department team interventions to enable more joined up care for residents.
- *Dementia Support Service (Dementia Hub)* – This service has established a clear pathway for people and their carers following a diagnosis providing a one stop shop for those needing information advice and guidance as well as practical support.
- *Delayed Transfers of Care (DToCs)* – Bromley's action plan continues to ensure a reduction in delays to patients being discharged from hospital. Improved integrated working has enhanced the hospital discharge process and continues to have a positive impact on local and out-of-borough discharge procedure and process and enhance both the quality of patient experience at discharge and anticipated performance.
- *Reablement* – Based on local data, the percentage of people still at home 91 days after discharge is 90.7% as of the end of March 2021. Bromley exceeded its planned target of 85%-90%.
- *Health Support in Care Homes and Extra Care Housing* – The establishment of the Bromleag Care Practice offering a dedicated GP service to care home residents. During the COVID-19 pandemic, the practice succeeded in vaccinating 100% of eligible Bromley care home residents by the target date and worked closely with the local Hospice to support residents who contracted Covid to be well cared for receiving Covid treatment in their place of residence.
- *Assistive technology* –Trials of new AT equipment to support the rapid assessment of need post discharge and appropriate care provision in the long term.
- *Community Equipment* – improved governance of prescription across the borough. Review and development of the equipment catalogue and integrated training opportunities for prescribers across the system.

A Strengths Based Approach

'Making Practice Personal', launched in 2020, is Bromley's whole service approach to community practice, personalised enablement and new models of commissioning and has been implemented in Bromley with the support of the Social Care Institute for Excellence.

Bringing together practitioners, commissioners and providers, it supports the transformation of services. It is underpinned by the core concepts of the Care Act, ensuring community opportunities, citizenship and personalised outcomes.

The model sets out standards, principles and approaches for staff delivering services. It places more emphasis on prevention and enablement and supporting people to live the life they want. It can be applied to every area of work – from frontline social work to systems, leadership and commissioning.

This systemic approach is underpinned by a culture change and learning and development programme to ensure sustainability.

Primary and Secondary Intervention Service

A key BCF investment has been the joint commissioning of primary and secondary intervention services from a consortium of local voluntary organisations. This contract was originally awarded to Bromley Third Sector Enterprise in 2017 to deliver the following services

- A Single Point of Access incorporating Information, Legal advice & Guidance
- Support to adults with Long Term Health Conditions
- Support to Elderly Frail
- Support on access to Employment and Education
- Support to Adults with Learning Disabilities
- Support to Adults with Physical Disabilities
- Carers Support services

This contract is being retendered in 2021/22 with the new contract to begin in September 2022. Enhancements made to the new service specification include:

- Additional provision for social care self-funders
- Expanded support to adults with a learning disability including ASD
- The addition of Dementia Respite Services
- Strength based approaches to delivery and outcomes
- A new priority of tackling loneliness

Changes to commissioning made through BCF since 2020 include:

- Integrated Commissioning Service – Local Authority and CCG community service commissioning resourced have been brought together to create the Integrated Commissioning Service
- One Bromley Discharge Partnership – BCF funds have been used to make permanent the interim Single Point of Access hospital triage and community discharge arrangements that were put in place in response to the Covid pandemic
- Recommissioning the Bromley Primary and Secondary Interventions Service
- Reviewing community equipment provision

Supporting People to Live at Home

Community consultation tells us that the preference of the overwhelming number of Bromley older people from all backgrounds is to be able to live at home for as long as possible and, if they must move, to live in supported housing that feels as much like home as possible.

We support people to be more independent by taking advantage of community resources, staying in their homes longer, taking responsibility for the management of their long-term health conditions (with support) and having community provision in place that helps to prevent, reduce or delay people needing statutory services. Collaborative and integrated commissioned provision includes:

- Bromley Well (Primary and Secondary Intervention Service) providing a comprehensive range of information, advice and guidance to support people in their resilience and self-care with targeted early help provision for elderly and frail, learning disabilities, mental health, long-term conditions, self-funders, unemployed, carers and homeless, including handyperson and help at home provision
- Domiciliary Care – all provision was recommissioned in 2020 with new patch and framework contractors scaling up services from August 2020. The new approach uses a trusted assessor model allowing providers to make some adjustments to care and support packages where needs change. Specialist provision includes discharge to assess support and palliative care
- Dementia Care – The Service include a clear pathway for people and their carers following a diagnosis providing one stop support for those needing information advice and guidance as well as practical support.
- CareLink Community Alarm and Assistive Technology (AT) to enable people to live in their own homes with greater independence via community alarms, fire or gas detectors and falls monitors which can simply be installed in a person's home and are linked to a response team via telephone or internet. Activity monitoring systems support long term care needs planning.
- Supported Living – Thirty adults with a learning disability are supported through the LB Bromley Supported Living Service
- Supported Housing options - In Bromley there are over 3,500 sheltered or retirement housing units, offering self-contained homes with communal facilities and services, usually with a manager to provide support and advice to residents as well as organising social events
- Extra Care Housing – LB Bromley commissions 271 units of Extra Care Housing including 15 step-down assessment units for people being discharged from hospital. The assessment flats are used to enable patients to recover and be supported to regain independence with the view of returning home or moving on to become long term Extra Care Housing residents.
- Proactive Care Pathway provides a full holistic assessment for people with frailty who are showing signs of deteriation providing a proactive health and care plan that supports them to remain well in the community
- Promoting Independence offer – brought together AT, Reablement, social care Occupational Therapists (OT's) and Moving and handling risk assessors (MHRAs) into a single promoting independence offer to sit alongside the newly established strength-based approach to assessments, the offer provided will be embedded as a default step in the social care assessment and review processes. These services provide interventions (including advice, equipment and adaptations to the home) to promote safety and independence and to reduce and delay the need for care and placements.

The recent Integrated therapies review, led by the Integrated Commissioning Board made significant progress in ensuring the deployment of health and social care therapy and rehab provision delivers a seamless and integrated approach to support residents. Several improvements were made to the system as a result, many of which had a direct impact on achieving timely discharge and positive outcomes for residents post discharge. For example the introduction of the SPA clinician to clinician hand over has streamlined acute to community transition and improved quality, Bromley Healthcare Home Based Rehab and LBB Reablement accessed through a single referral route, closer working of community health and social care therapy via discharge MDTs especially around complex patients as well as the introduction of a Rapid Access Therapy Team that can provide access to urgent and unplanned therapy needs to prevent an admission or re-admission.

Wider infrastructure changes have also taken place with the community health provision restructured into an ‘urgent response and rehab’ and ‘community therapy’ offer whilst the LA have brought a range of provision together including Assisted Technology, OT, MHRA and Reablement to provide a streamlined promoting independence offer. As a result, the local offer is clear, robust and allows residents to transition through the system smoothly receiving the therapy assessment and intervention that is right for them.

The local reablement and rehabilitation offer has been brought together via a single triage route enabling improved access and maximising resources. Throughout the pandemic the Reablement and Rehab offer was a key enabler to the success of the system in responding the challenges of covid and enabling hospital discharge. Reablement and Rehabilitation are now used as a default step for all patients who have not previously received care to ensure maximised independence and improved outcomes wherever possible. During 19/20 92.5% of residents receiving reablement remained at home 90 days post intervention (this is the cleansed figure, differing from the nationally reported 63%). As the local partnership expands the use and capacity in Reablement services it is expected a more complex cohort of patients will be receiving Reablement input. As a result of this, the target for 21/22 is 85% of people receiving Reablement to remain at home 90 days post discharge from the service – this remains higher than the national average. Further work on developing the current assisted technology offer across health and social care is being supported by BCF with funding to pump prime a programme of work. The aim of which is to use AT to promote independence and virtually monitor health conditions in the community avoiding an admission or enabling an early supported discharge. So far, this work has been successful in using AT as part of the Home First offer as well as mobilising virtual health monitoring technology in care homes. Going forward virtual assessment flats are being considered as part of the Extra Care Housing development work with consideration as to how AT can be used as part of the developments in the Hospital @home model with a focus on supporting people with long term conditions to be supported at home.

As a result of all the work locally to support people to remain at home, there was a slight reduction in the number of residents, per 100,00 moving into a placement at 420.5. However, locally the length of stay in care homes has considerably reduced as we see a higher turnover or older adults reflective of the system being able to support people with more complex needs at home. Further work around home first and increasing reablement and AT for residents potentially requiring a care home is expected to further reduce the number of admissions in this area.

Supporting Discharge

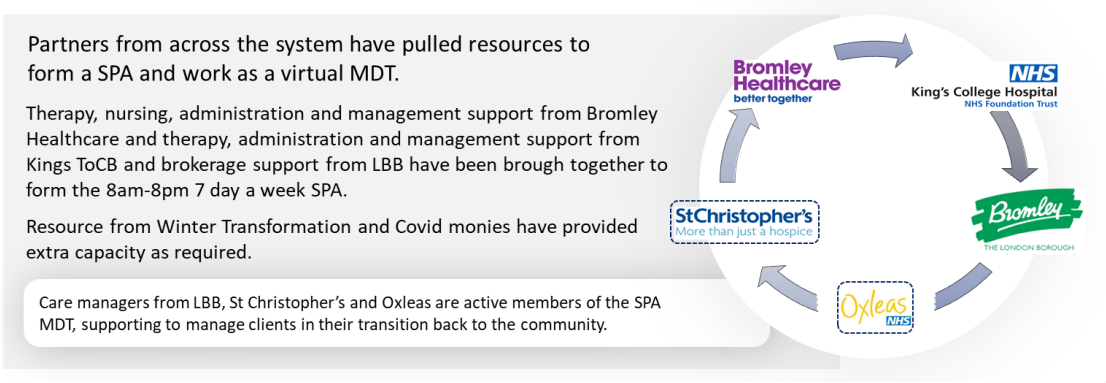
Hospital Discharge

Integrated commissioning is used to procure and lead out of hospital services locally. Led through a CCG and LBB joint appointed Associated Director, BCF monies contribute to supporting people to be discharged from hospital in a safe and timely manner. Further investment has been made through funds attached to the Hospital Discharge Policy and used to successfully enhance and formalise the Hospital Discharge Partnership which has created an infrastructure that enables safe and timely discharge. The Partnership received the top industry Municipal Journal Achievement Award for integrated health and care working in September 2021.

The Single Point of Access (SPA) and hospital Discharge pathways, which make up the Bromley discharge Partnership, was set up in response to the Hospital Discharge Service: Policy and Operating Model Published on 19 March 2020. The aim of the integrated hospital discharge model, was to:

- Eliminate any delayed transfers of care enabling patients to be discharged as soon as they were medically fit.
- Reduce length of stay for patients requiring supported discharge.

- Ensure residents receive timely, personalised care at home, or in a care home where this is most appropriate.
- Improving Outcomes for residents being discharged from hospital
- Support recovery and regaining independence or where appropriate enabling residents to die peacefully in their chosen place of death.



Although the pandemic and responding to national requirements was a significant catalyst to the change, the mobilised integrated discharge model was locally driven building on existing Better Care Fund supported schemes including the Transfer of Care Bureau, additional investment in Reablement and Intermediate Care services. The additional funds received by the government to support hospital discharge was used across the health and care system to enhance and develop the best practice integrated discharge model that has been achieved locally.

All local areas were required to put in place a streamlined hospital discharge function – the ONE Bromley's version is an exemplar of integrated working built on the foundation of excellent local relationships and willingness to share risk for the benefits of residents. The partnership is also committed to innovation and challenging traditional roles, responsibilities, and organisational boundaries, thinking more creatively to achieve better outcomes for the local population.

To deliver this, the SPA comprises the following components:

- A full discharge to assess (D2A) model moving all therapy and long-term care assessments from the hospital into a more familiar community setting.
- Bringing together all community referral points into a Single Point of Access (SPA).
- Removing multiple referral forms for community services and introduced a clinician-to-clinician referral bringing together acute and community knowledge to facilitate the most appropriate and least restrictive post-discharge support.
- Brought together post-discharge health and social care assessment capacity and support into a virtual Multi-disciplinary Team (MDT) focusing resources on recovery and regaining independence and meeting presenting needs.
- Introduction of a welfare call methodology for all discharged patients to improve safety and quality of transfers of care. A follow up call is made on the same or following day of discharge to ensure all needs are met
- Integrating post discharge pathways including rehab and reablement used flexibly to underpin the whole system and ensure access to capacity.

Achieving positive outcomes and promoting independence and recovery is a key aim of the Hospital Discharge Partnership. Social Care input is provided at key points in the hospital discharge process to support timely and effective decision making with an increase in reablement and rehabilitation capacity offering this as a default step for residents who have not previously received care and

support to achieve maximum independence. Specialist Moving and Handling Risk Assessors review double handed care and support packages to ensure the least restrictive level of care is provided with a Discharge to Assess (D2A) model being used to assess clients in a more suitable community-based environment. The MHRA team can regularly reduce care from double to single handed, by the prescription of equipment and the teaching of new techniques to safety provide care. This promotes dignity for people and maintains capacity in the domiciliary care sector. OT and reablement services support individuals to reach their potential on discharge and for those with permanent functional decline, they support with lifestyle redesign. The service works with people over a 6 week period to identify individual goals within chosen areas of daily living. The outcomes for clients are improved independence and/or adaptation to their new level of function, which promote wellbeing and reduce dependency.

Since the introduction of the SPA, from April 2020 to February 2021 there was a 25% reduction in length of stay for patients requiring a supported discharge which equates to 11,730 saved bed days with an estimated value of circa £3,870,900 based on an average medical bed cost of £330pn. 4572 social care services were put in place to support clients to be safely discharged into the community, including 2010 packages of care and 487 placements brokered. The SPA facilitated 48% of patients requiring community support to be discharged within 6 hours of becoming medically fit for discharge with 80% discharged on the same day.

Changes in BCF investment made in 2021/2022 are helping to make these SPA arrangements permanent. These arrangements are to be further enhanced through an additional and ongoing investment of £0.5M made by Kings College Hospital NHS Foundation Trust
Having gone live with a new social care information management system, the council has now also gone live with the new a Health Information Exchange functionality. This enables the council and health providers to share a controlled level of patient/service user information. All GDPR due diligence has been undertaken and a Memorandum of Understanding has been signed, the technology has also been set in place. Amongst other advantages, this will enable an efficient information exchange at the point of hospital discharges.

Home First

For people with more complex care and support needs an effective Home First Model enables residents who would have previously been discharged to a placement to be discharge home with intensive assessment, care, and support. The Home First model is delivered through a Multi-disciplinary Team huddle including social care, therapists, AT specialists, Care Home Support Nurse, brokerage, and hospital discharge co-ordinators that scrutinise, develop and review discharge plans. Use of assisted technology to support assessments alongside input and assessment from the specialist integrated team has resulted in over 80% of residents being discharged on the Home First Pathway remaining at home.

In addition to offering enhanced care at home, the Home First offer also includes access to interim beds offering a 2-week assessment period in residential care. Access to the beds is manged through the Home First Huddle with dedicated assessment capacity to ensure timely move-on through the provision. To date, 70% of residents accessing interim assessment beds returned home. To further enhance this model, dedicated OT provision is being funded to enable clients with more complex needs to access the provision and ensure maximum impact of this resource.

As a result of all the positive, integrated work undertaken in Bromley, in the context of the second highest older adult population in London, 92.5% or residents were discharged to their usual place or residency in 19/20 and 92.9% 20/21 which is in line with the London and national average and higher than statistical neighbouring boroughs including Bexley at 84.1% in 19/20 and Greenwich at 79%. Achieving such high performance is testament to robust integrated service model deployed locally to ensure, wherever possible, residents can be discharged to their usual place of residency to recover and regain as much independence as possible.

Reducing Length of stay (LOS) continues to be a key focus for system partners in Bromley. Alongside reducing admissions and achieving timely discharge (see maetrix 8.1 and 8.3) there has also been considerable work undertaken locally to reduce LOS. This includes Stranded reviews, led by the BCF funded Transfer of Care Bureau which takes place twice per week to review all patients +14 and +21 days, a daily review of all patients noted as medically fit for discharge by the ToCB team leader as well as ongoing audit and scrutiny of discharge performance.
Performance on discharge for patients on pathways 1 to 3 continues to be exemplary with 80% discharged on the day a patient is declared Medially Safe For Discharge. The remaining 20% are for care home placements with performance currently better than the national and neighbouring borough average of >3days and the complex care and Home first Huddle continuing to improve the timeliness of discharge for more complex patients. The introduction of a Mental Health flow manager is expected to further reduce LOS for patients with temporary delirium and those with complex needs because of their mental health condition.

The Trust continue to mobilise the SAFER bundle including Red to Green which is expected to provide more robust oversight and identification of patients where there is an internal delay or no active intervention being provided. In addition, ensuring the medically fit status is effectively recorded will also improve data quality and enable the effective deployment of resources to achieve discharge and reduce LOS. Currently, of those recoded as MSFD, on review, 50% are not fit for discharge. The development of the Bromley @home model is also expected to provide early supported discharge which will further reduce length of stay delivered through a shared care model.

Winter Plan 2021/2022

The BCF winter funding allocation of £1,455,000 is deployed through the One Bromley System Winter plan which brings together a single view of how the local health and social care system will proactively manage additional demands felt throughout winter. The Plan is developed with oversight from the Bromley A&E Delivery Board member organisations and challenged and reviewed at One Bromley Executive and through the London Borough of Bromley scrutiny committees. The Winter Plan 2021/22 and this BCF Plan share the same joint priorities

The plan is also supported by a “Together through winter” comms and engagement campaign in line with the binding theme of recognises there is no single service or organisation that can overcome the anticipated challenges alone and we will get through winter by working together as One Bromley. Further work on developing the current AT offer across health and social care is being supported by BCF with funding to pump prime a programme of work.

DFG and Adaptions

There is an undersupply of fully accessible homes. This is being addressed through two means. Firstly by ensuring that developers include a proportion of accessible homes within new housing developments, and secondly by seeking to maximise the number of properties that can be successfully adapted to meet the needs of older and disabled people. Our approach recognises that adaptations have a critical role to play in:

- supporting older people and disabled people and their carers to manage their health and wellbeing in the home, reducing and delaying the need for further care and support
- extending safe, independent living in the home and delaying moves into residential care
- efficient, cost effective delivery of health and care services within the home
- reducing demand for NHS services/ reducing people delayed in hospital while awaiting home adaptations
- prevention of high-cost acute incidents, such as falls in the home.

A Disabled Facilities Grant Panel takes forward this approach and includes representatives from Housing, Social Care and Occupational Therapy professionals. The panel considers applications for Disabled Facilities Grants which are then administered and delivered by Bromley’s Housing

Improvement Team. Social Care and Occupational Therapy staff work closely with Health colleagues in identifying where changing health and care needs necessitate specialist equipment and/or adaptations to be made in order to support people to remain in their own home. In the current year to date we have spent circa £1.1 million on Disabled Facility Grants.

During the pandemic work decreased on Disabled Facility Grants due to self-isolation and other Covid related factors, but this work has now recommenced. During the main period of the pandemic the Housing Improvement team were able to put in place additional measures to assist with hospital discharge. This went beyond include adaptations and included clean and clear jobs to ensure a safe and comfortable return home. During this period circa £11k was spent on such works.

Property condition can impact on health, both in terms of slips, trips and falls, as well as more general health issues such as lack of warm damp free home. To this end we look to improve housing conditions of older people and residents with a disability through Safer Homes Grants based on the understanding that relatively low-cost works can dramatically improve and preserve health as well as avoiding pressure on health and care services. In the current year to date we have spent circa £26k on such grants.

When it is not possible to meet client need through the adaptation process, rehousing is proposed. OTs within the Housing Service assess applicants needs to identify the type of property required and monitor voids to support those waiting to find appropriate housing.

Equality and Health Inequalities.

Across health inequalities measures the population of Bromley perform similar if not better than the London and England average in all performance indicators for both males and females. Females perform better in all performance categories than males, except for disability-free life expectancy at 65.

Healthwatch Bromley regularly tracks and tests patient and service user experience of health and care services with a focus on residents with protected characteristics.

The update of the demographic profile for our Joint Strategi Needs Assessment (JSNA) made earlier this year has highlighted the following issued with regards to population changes and health equalities and inequalities for people with protected characteristics under the Equality Act 2010:

- The latest (2021) estimate of the resident population of Bromley is 330,379, having risen by 27,705 since 2001.
- The proportion of older people in Bromley (aged 65 and over) is expected to increase gradually from 17.8% of the population in 2021 to 18.7% by 2025 and 20.2% by 2031.
- The latest (2021) GLA population projection estimates show that 21% of the population is made up of Black, Asian and minority ethnic groups, this is expected to increase to 24% by 2031
- The ethnic minority group experiencing the greatest increase within Bromley's population is the Black African community, with an increase in the population size of 16.6% by 2026 and 29.5% by 2031 when compared to 2021
- Internal and international migration into Bromley is decreasing by year (2015-2019). There has been a net emigration out of Bromley since 2015. Since 2016 the main contributor to an increase in population is natural births rather than migration into Bromley.
- North West and North East Bromley have the highest levels of deprivation, whilst Central and South Bromley have much lower levels.

From the 2011 Census data we can predict the number of people who have a disability or long-term health problem that limits their day-to-day activities a lot or a little (Table 13). From the Census it was calculated that 7% of residents in Bromley had a disability or long-term health condition that effected

their day-to-day activities a lot, 8% said they were affected a little by their disability or condition. These percentages are similar to the London average, but less than the proportion in England

The top 5 causes of years lived with disability in Bromley has remained the same from 2009 to 2019. This includes musculoskeletal disorders, mental disorders, other non-communicable diseases, neurological disorders, and diabetes & CKD. There has been an increased impact to years lived with disability caused by unintentional injury, digestive diseases, and nutritional deficiencies. There has been a decrease in the impact caused by chronic respiratory diseases, cardiovascular diseases and maternal & neonatal diseases

One of the main burdens of disability in Bromley is mental health disorders. The estimated prevalence of common mental health disorders in Bromley is 15.1% for 16+ years and 9.1% for 65+ years (PHE: Fingertips, 2017). People with a learning disability have a shorter life expectancy. This is due to them being disproportionately affected by certain health conditions including coronary heart disease, respiratory disease and epilepsy. Bromley Quality Outcomes Framework (QOF) Prevalence of learning disabilities is 0.3% (PHE: Fingertips, 2019/20), using the 2021 projections this is approximately 991 people.

Specific activities in support of addressing health inequalities include:

- *Bromley Integrated Mental Health and Emotional Wellbeing Strategy* - A joint plan to support communities and individuals to have improved mental health and wellbeing. This strategy sets out an approach to prevent children and adults reaching a crisis point through the provision of a strong prevention and early intervention offer. It also puts in place a joint plan for the provision of a number of important services for people with mental health challenges, including good advice and information, talking therapies and counselling, employment and training schemes, mental health support in schools and supported housing. Specific actions look to respond to the impact of the pandemic on residents' emotional health.
- *Primary and Secondary Interventions Service* – Services and pathways proactively targeting those most at risk of health inequalities with specific provisions for elderly frail, people with learning disabilities and physical disabilities (see details above.)
- *Tackling Loneliness Strategy* – a new strategy across all ages in response to increased isolation as result of pandemic lockdown
- *Recommissioning Learning Disability Day Services* – Services have been recommissioned with a focus on community-based activities and integration including support on independence and self-care
- *Covid Vaccinations Programme* – the joint programme has been amongst the more successful in London with targeted work at vulnerable communities and specific focus on Black, Asian and minority ethnic residents

As is the case in many parts of the country COVID-19 has disproportionately impacted different populations of Bromley, through the risk of infection and death, impact and access to services and the wider economic impacts. Recommendations and next steps from our new JSNA chapter on Covid-19 are as follows:

- Engage with high-risk groups to better understand their experience of the COVID-19 pandemic and how it has exposed and exacerbated the inequalities they face
- Focus on Social isolation and loneliness
- Focus on Mental health and wellbeing
- Reducing long term risk factors for COVID
- Understanding Long COVID
- Recovery of services

These recommendations will inform BCF Planning from 2022/2023