King's College Hospital NHS Foundation Trust | Bromley Healthcare better together | Oxleas NHS | St Christopher's More than just a hospice | BTSE Bromley Third Sector Enterprise | Bromley GP Alliance | Bromley Primary Care Networks | Bromley The London Borough | South East London NHS

ONE BROMLEY

South East London Strategy and Joint Forward Plan and Developing the One Bromley 5 Year Strategy

June 2023

Two 5 year plans

South East London Strategy and Joint Forward Plan

One Bromley 5 Year Strategy

Incorporates Bromley's delivery plan of the South East London Joint Forward Plan

SEL Strategy published in March 2023 and Joint Forward Plan (draft) published in April 2023. As a minimum, the JFP should describe how the ICB and its partners intend to arrange and/or provide NHS services to meet their population's physical and mental health needs. This should include the delivery of universal NHS commitments, address ICSs' four core purposes and meet legal requirements. The SEL JFP requires a statement from each Health and Wellbeing Board.

South East London ICS Strategy

ICS Priorities

Become better at preventing ill health and helping people in south east London to live healthier lives

Ensuring parents, children and families receive the most effective support before and during childbirth and in early years

Ensuring that children and young people receive early and effective support for common mental health challenges

Ensuring that adults in south east London receive early and effective support for common mental health challenges

Ensuring that people, including those with continuing health needs, can conveniently access high quality primary care services

Full document here: Integrated Care Strategic Priorities for 2023-28 (selondonics.org)

South East London Joint Forward Plan

The Integrated Care Board Joint Forward Plan sets out our medium term objectives and plans, at both a borough level and from the perspective of our key care pathways and enablers, to ensure that we are developing a service offer to residents that:

- Meets the needs of our population.
- Demonstrates and makes tangible progress in addressing the core purpose of our wider integrated care system – improving outcomes in health and healthcare, tackling inequalities in outcomes, experience and access, enhancing productivity and value for money and helping the NHS support broader social and economic development.
- Delivers national Long Term Plan and wider priorities, all of which resonate from a SEL population health perspective.
- Meets the statutory requirements of our Integrated Care Board.

Note: Once at Place we have approved our One Bromley Strategy the Bromley 'Place' slides in the SEL JFP will be updated with our Bromley approved slides

Full document here (c. 250 slides): Joint Forward Plan - South East London ICS (selondonics.org)

South East London ICB Joint Forward Plan

The Joint Forward Plan provides the following:

- A strategic overview of our key priorities and objectives for the medium term.
- A high level summary of the short term actions that we will take, working with partners, to ensure the key milestones that support us in meeting these medium term objectives are secured, with further underpinning detail included in our 2023/24 and subsequent operational plans.

This is the first Joint Forward Plan and it will be refreshed annually to:

- Take account of implementation and outcomes over the previous year, including any learning to be applied to our future plans.
- Reflect any changes required due to new or emerging issues or requirements, be they related to population health, feedback from our communities and service users or service delivery issues and opportunities.

Full document here (c. 250 slides): Joint Forward Plan - South East London ICS (selondonics.org)

One Bromley Strategy

Forms part of the SELICS Joint Forward Plan

Our draft One Bromley 5 Year Strategy

- A population health approach
- Focus on prevention at scale, continuity of care and a more holistic approach to people's needs
- A bold vision for Bromley: delivery will involve significant changes in how agencies work together for our population
- Developed through discussion of One Bromley partners across 2022 and 2023 with support of the King's Fund

Strategy structure

- Bromley's population and health outcomes
- Priorities
- Principles of how we will deliver together
- Programmes
- Projects
- Enablers

Our draft strategy

Our population

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

Health outcomes for our population

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

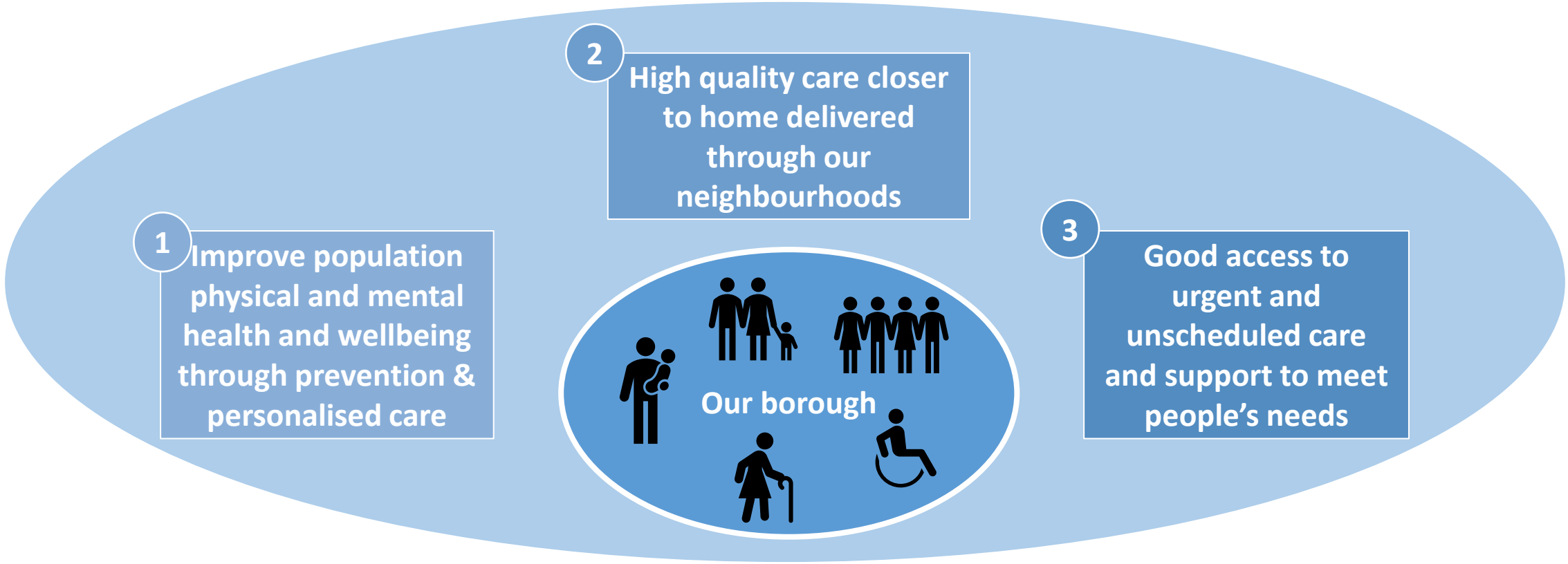
Inequalities within our borough

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

What we've heard from the public

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

Priorities for One Bromley 2023-2028



One Bromley culture and wider enablers

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

How will things be different in 5 years' time?

- More Bromley residents live longer lives in better health
- Frail, elderly and other people at risk of deterioration get more proactive support – reducing need for urgent care
- Patients' same day health and care needs are better met in the community
- People needing mental health support are helped earlier and closer to home
- Children and young people access more joined-up physical and mental health and care support
- We work seamlessly across organisational boundaries

Overarching principles

What are the values-based principles we need to achieve this ambition?

We will…

- **Embed One Bromley priorities** into our own organisations' priorities
- **Engage within our organisations** on our priorities at all levels
- **Work together as one team across organisations** by empowering our staff to work together for the benefits of patients and service users
- **Pool our insight and expertise** to develop creative ways of delivering care and support
- **Harness the power of our communities and third sector** so residents are empowered in their personal care and health decisions, in shaping services to meet local needs and being part of resilient communities
- **Allocate resources differently** shifting resources in Bromley on an agreed basis to areas where they could have greatest effect and reducing duplication

Our strategy in detail

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

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

2 High quality care closer to home delivered through our neighbourhoods

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

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

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

Our strategy in detail

1. Improve population physical and mental health and wellbeing through prevention & personalised care
2. High quality care closer to home delivered through our neighbourhoods
3. Good access to urgent and unscheduled care and support to meet people's needs

Priority Programmes

1) Evidence driven prevention and population health
2) Neighbourhood teams on geographic footprints
3) Implement care closer to home programmes
4) Primary care sustainability
5) Integrated urgent care

ONE BROMLEY

Programme 1: Evidence driven prevention and population health

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

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

How we will secure delivery

Actions for 23/24

- Population health analysis plus local intelligence held by health, care, third sector and SAFER Bromley partners to identify those living with long term conditions, frailty, experiencing health inequalities (Core 20Plus5) and at risk of emergency admission.
- Utilise care closer to home initiatives (see Programme 3) to identify and support those we could help the most – e.g. Children's hubs relationships with schools; development of Bromley Mental Health Hub and single point of access; CAMHS and Bromley Y single point of access offering tailored offer to service users
- Case management approach for complex and vulnerable individuals to provide more holistic, anticipatory and coordinated care, using a plan-do-study-act approach
- Further understanding of who communities trust and engage, including with VCSE
- One Bromley taskforce and strategic board to plan and deliver improved vaccinations uptake, including through a Health 'one stop shop' in central Bromley.

Actions for 24/25

- Engagement through neighbourhoods with communities about the root cause of current levels of utilisation of prevention and screening services and self care.
- Delivery of a new Bromley Mental Health and Wellbeing Strategy by 2025
- Linked to above, explore need for place-based prevention service supporting health checks & management of chronic conditions at scale, embedded in neighbourhoods.
- Evidence analysis support - support for staff at all levels and across providers to interrogate, manipulate and interpret service and populations data.
- Expansion of use of care closer to home initiatives for more complex areas requiring greater cross boundary working – e.g. Children's hubs: LGBTQ+ and young carers.
- Influencing partners beyond health and care with evidence from engagement

Intended outcomes in 5 years time

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

Programme 2: Neighbourhood teams on geographic footprints

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

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

How we will secure delivery

Actions for 23/24

- Grow early initiatives, including CYP hubs, wellbeing café, diabetes outcomes improvement programme to gain and share learning of this joint working
- Deliver a programme of engagement with providers, local authority and third sector to establish core principles and geographic footprints of INTs, and to develop local leadership groups at neighbourhood level
- Agree between One Bromley partners a roadmap of services, staffing and structures commitment to neighbourhoods
- Start conversations with local populations on our plans
- Baseline the existing organisational capacity and capability change, at system, place and neighbourhood levels, to ensure systems can undertake their core operational and transformation functions. Link with understanding of community assets and tools.
- Workforce and skills gap analysis and plan development
- Commence needs analysis and scoping for improved community access to diagnostics and wider primary care services (dentistry, pharmacy and optometry)

Actions for 24/25

- Establish neighbourhood forums of providers for ongoing conversations about shaping services offered and dock in enablers, e.g. population health analysis
- Commence shift of organisations' structures to neighbourhood footprints – including translations of secondary and mental health consultant capacity from outpatients to neighbourhood MDTs for target clinical specialties
- Co-production skills development with neighbourhood teams to set selves up for future development work

Intended outcomes in 5 years time

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

Programme 3: Implement moving care closer to home

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

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

How we will secure delivery

Actions for 23/24

- Continue to work with communities co-develop our care closer to home programmes to support equitable access and improved outcomes
- Continue building clinical confidence in pathways – e.g. Hospital at Home pull models and weekend service offer
- Children's Integrated Health Teams develop and go-live across all PCNs
- Expand adult Hospital at Home to include remote monitoring and as part of a holistic community urgent response service
- Development of the Bromley Mental Health Hub, a joint Oxleas/VCSE service.
- Work to integrate the Bromley Mental Health Hub with other community mental health wellbeing services around a Single Point of Access.
- Join-up Bromley Mental Health Hub with Bromley Talking Therapy Services
- Deliver an integrated Single Point of Access across CAMHS/Bromley Y to deliver a tailored offer across services

Actions for 24/25

- Commence linking working of care closer to home services with neighbourhood teams
- CYP transformation embedded following contract specification updates
- Delivery of new Bromley Mental Health and Wellbeing Strategy by 2025
- Continued work across all programmes with communities to refine the service offer.

Intended outcomes in 5 years time

- Reduction in waiting times for children's health services
- Improved access to adult wellbeing early intervention and prevention
- Reduced need for adults to access secondary mental health services
- Reduced need for adults to attend hospital for acute care
- Reallocation of resources to reflect change in where patients are treated
- Improvement in Bromley ranking in London for recorded depression
- Improved outcomes for users of all care closer to home programmes
- Communities feel that they own the services they have supported build through co-design

Programme 4: Primary care sustainability

Establish and deliver development plan to support primary care sustainability

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

How we will secure delivery

Actions for 23/24

- Continued delivery of primary care events to collaborate on transformation of general practice and the local system
- Second phase of the primary care needs analysis to evaluate the developments to date and agree future model(s) in general practice
- Share insights and benchmarked outcomes on delivery of primary care across clinical care and patient outcomes at practice and PCN level, e.g. Clinical Effectiveness, QOF, and other data sources for long term condition outcomes.
- Identify where additional investment or services may be required to ensure equitable access and suitable provision for our patient populations
- Continue clinical quality improvement plan: 1) quality improvement methodologies, 2) reviewing demand and capacity, 3) digital transformation - online consultations, clinical monitoring and patient-led management of health needs
- Maximise use of existing estate – focus on fit for purpose and appropriate scale
- One Bromley Strategic Workforce programme, Training Hub and partners collaborate on attracting people to work in primary care in Bromley and new routes into primary care. Develop Portfolio working model for Bromley practices to attract Portfolio GPs.

Actions for 24/25

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

Intended outcomes in 5 years time

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

Programme 5: Integrated urgent care

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

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

How we will secure delivery

Actions for 23/24

- Develop borough-wide pathway to meet same-day care needs for patients, regardless of access channel, clarifying role of general practice and meeting seasonal demand
- Admission avoidance: Urgent Community Response, including Hospital at Home, fully supporting all 9 national clinical conditions and aligned with general practice.
- Admission avoidance: front door ED streaming, SDEC services with embedded speciality capacity, mandated heralding of professional referrals to ED.
- Expanded High Intensity User Programme focused on most frequent ED attenders and supported by population health analysis as available
- Clarified primary care access to urgent mental health care and support
- Mainstream Home First and Discharge to Assess (D2A) and commence work on integrated D2A pathways for clients with more complex health and care needs
- Transfer of Care Bureau / Single Point of Access pathways – expand current supported discharge process to a broader offer of proactive support to prevent readmissions
- Children's hubs across borough to support community response (see Programme 3)

Actions for 24/25

- Agree between partners and with our communities an improved integrated urgent care model which enhances sustainability – working with developing neighbourhood teams to calibrate activities at Place and Neighbourhood level
- Needs analysis and scoping for improved community access to diagnostics and wider primary care services to avoid hospital attendances
- Utilise emerging neighbourhood teams to support delivery of self care messaging – with supporting collateral e.g. 'when to escalate' booklets for parents, training course for informal carers of people with long term conditions.

Intended outcomes in 5 years time

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

Enablers

Workforce

- **Workforce plan to support each of the priorities –** including Integrated Neighbourhood Teams workforce planning tool and resource
- **Recruitment** (current and future workforce)
  - One Bromley recruitment campaign; One Bromley 'come and work with us' website page on ICS website; Local Recruitment fairs for health and care roles
- **Retention** (innovative roles, shared roles, wellbeing and skills development)
  - Building staff agreement for joint services; Joint training and wellbeing programmes
- **System working** (Organisational Development to support wider understanding of the system, working across silos, development of teams employed across the system, system leadership)
- **Widening participation and understanding of careers**
  - One Bromley Springpod, One Bromley Cadet programme
- **Business intelligence on workforce** – location, roles, contracts

Digital

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

Estates

- **Local estates planning** with all local partners through the Local Estates Forum, developing the local and primary care estates strategy
- **Utilisation of estate across Bromley** beyond existing NHS properties, including shared accommodation and hub working
- **Levering investment** into the Borough to support estates development
- **Progress the development** of the Bromley Health and Well Being Centre and other capital schemes
- **Delegations** to support decision making
- **Improve the quality** of existing estate and ensuring robust contractual arrangements in place to provide stability for future use.

Finance

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

Enablers

One Bromley Culture

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

Communication and engagement

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