Appendix 1

Bromley Better Care Fund Plan 2023-2025

Contents

Introduction

The Government's Better Care Fund (BCF) programme supports local health and 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.

This Plan sets out how BCF resources are being used to further health and care joint working in Bromley in 2023-2025. The Plan is approved and overseen by the Bromley Health and Wellbeing Board and submitted to NHS England as part of the BCF Grant conditions. The contents of the Plan are determined by criteria set by the Department for Health and Social Care.

The organisations involved in preparing and delivering on the Bromley Better Care Fund Plan for 2023-24 are:

- London Borough of Bromley (LBB)
- South-East London Integrated Care Board (SELICB)
- 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 joined-up approach to integrated, person-centred services across health, care, housing and wider public services in Bromley has, since 1 July 2022, been led by the Bromley Local Care Partnership, the Bromley Place Based Board for the South East London Integrated Care System (SELICS.) This partnership board is supported by the ONE Bromley Executive partnership comprised of senior staff from across local care, health and housing agencies.

This BCF Plan is aligned with and supports the ONE Bromley 5-Year Health and Care Plan which was developed through a series of partnership workshops ran through 2022-23 and consulted on with local community groups, patients groups and residents.

The Plan was agreed by the Bromley Health and Wellbeing Board who have oversight of the plan and will receive a quarterly update on the Plan's progress and achievements against the BCF metric.

Executive Summary

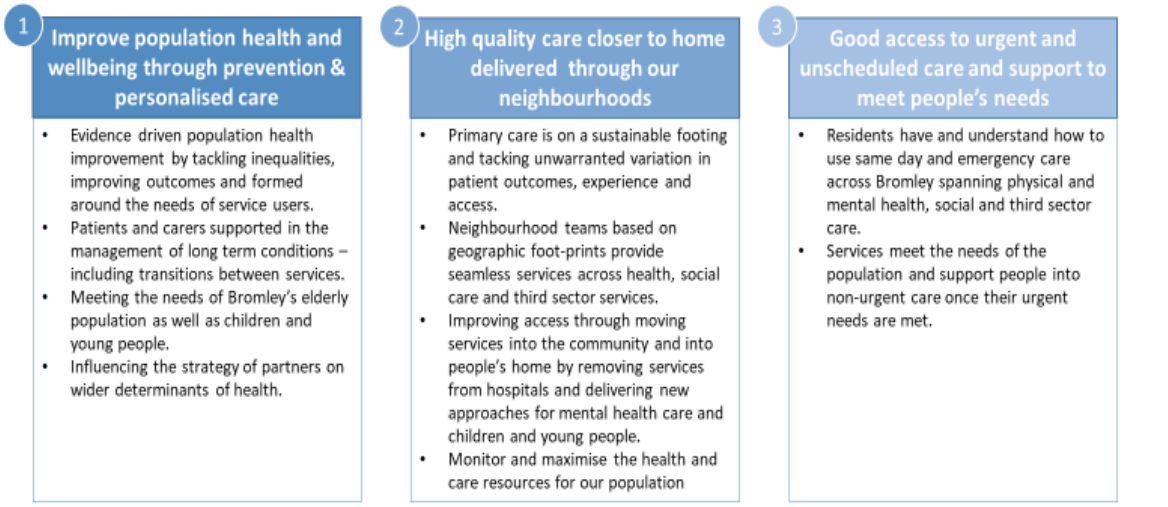
This BCF Plan shows Bromley's journey of continuous development against the BCF Key lines of enquiry and metrics. This progress is led and supported by sustained collaborative working and effective joint leadership from across the ONE Bromley partnership.

The 2023-25 Plan progresses further the local delivery against the shared objectives to promote independence and support people living at home for as long as possible, intervening early to prevent deterioration and reduce the need for hospital admissions whilst working together to jointly improve outcomes for people being discharged from hospital. Improvement was shown across all metrics during 22-23 with the end of year review showing improved delivery against all priorities set out in the years Plan.

Since the 22-23 Plan the ONE Bromley Partnership has developed and agreed in May 2023 the ONE Bromley 5-year strategy which introduces three key priorities to progress joint working and this BCF Plan:

1. Improving population health and wellbeing through prevention and 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

Our strategy in detail



Key developments from the 2022-23 Plan and significant changes BCF fund allocations for the new Plan include:

- An agreed methodology for population health management has been used to inform the new 5-year plan, and priorities.
- A commitment across partners to develop joint and integrated services at the partnership level with a focus on prevention and early intervention. This builds upon existing neighbourhood services

- A commitment to move more services out of our local hospital and services closers to where people live. Developments such as the establishment of multi-agency Children's Health Hubs are learning from our hospital at home and virtual ward pilots
- The continued development of urgent and unscheduled care services including a new winter plan for 2023-24 – supported through the Hospital Discharge Grant and underpinned by the High Impact Change Model for discharge.
- The introduction of a new Housing with Care Strategy that will review current special housing stock and support and expand provision of extra care and supported living schemes. This will be accompanied a Bromley Housing Assistance Policy as allowed for under the Regulatory Reform (Housing assistance) Order that will better enable the spend of Disabilities Facilities Grant (DFG.)
- Plans to recommission housing support for mental health service users including the deregistration of mental health care homes to increase supported living opportunities and an integrated housing support service to be contracted from October 2024
- The extension of pilot arrangements to further increase Direct Payments take up by residents through supporting staff and service users
- Further investments in assisted technology
- A review of how the Better Care Fund, recognised locally as a key vehicle for integration, prevention and improving outcomes for the population, is used to support our plans used to support our plans and objectives

National Condition 1: Overall BCF Plan and approach to integration

Joint priorities for 2023-2025

This BCF Plan 2023-2025 is in alignment with, and in support of, the ONE Bromley 5-Year Plan. In creating the 5-Year Plan the ONE Bromley partners held a series of workshop facilitated by the Kings Fund think tank over a 12-month period. The workshops looked at best practice from across the country and, developed and agreed the population health management approach to determining priorities and the action plans in support of achieving these priorities. The priorities and actions plans were further informed through consultations with patients, services users, carers and community organisations.

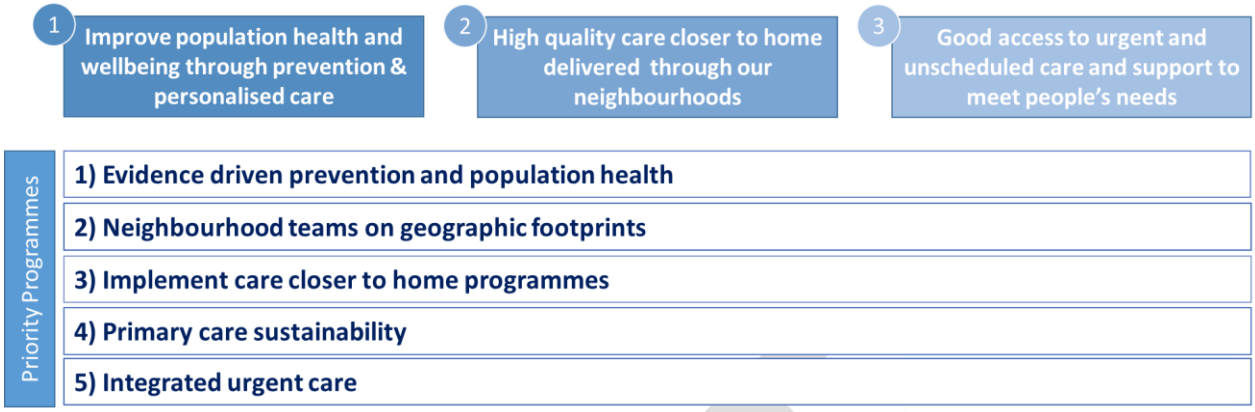
The ONE Bromley Plan is the Place Based contribution to the South East London Integrated Care Service, Joint Forward Plan.

The Three strategic priorities of the ONE Bromley 5 Year Plan, which will inform the BCF activity during 2023-25 are:

1. Improve population 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

The ONE Bromley 5 Year Plan makes a commitment to ensuring that the local authority and ICB finances and resources are used effectively to achieve maximum impact whilst delivering sustainable models of care, that meet population need.

To achieve the 3 strategic priorities of the ONE Bromley Plan, 5 priority programmes have been established. The priorities and programmes are summarised in the table below.



The Joint Priorities, Better Care Fund metrics and National Conditions are incorporated into the operational plans that support the direction and oversight of the 5-Year Plan.

Approaches to joint/collaborative commissioning

In 2020 the Council and the then CCG established an Integrated Commissioning Service with an Assistant Director of Integrated Commissioning appointed as a joint postholder across the CCG (now ICB) and Local Authority. All out of hospital health and care services in Bromley are commissioned through this service. A section 75 agreement totalling £71.5M details specific integrated commissioning and service arrangements.

An Integrated Commissioning Board, jointly chaired between the LBB Director of Adult Services and SELICS Place Executive Lead, leads on the development and oversight of the joint commissioning arrangements. Further oversight is made by the Health and Wellbeing Board with quarterly reports on progress across all joint commissioned programmes and BCF Plan performance.

The Council and ICB intend to develop further this integrated commissioning approach in 2023-24. This will include a focus on joint arrangements for commissioning services to children and young people as well as a further expansion of joint commissioning services for adults, informed by the review of ICB commissioning undertaken in response to the Hewitt Review.

The current services commissioned through the BCF, and priorities for BCF investment in health and care integration include:

- Primary and Secondary Intervention Service contract delivered through the VCS consortium Bromley Third Sector Enterprise – known as the Bromley Well Service. The service provides early intervention, prevention and VCS support service for people meeting a statutory threshold. Through 2023-25 developments will include delivery at neighbourhood level to improve closer working of the VCS and wider services to improve prevention and early help outcomes and strengthen community Assets.
- Significant investment from BCF into the successful integrated hospital discharge pathways including D2A, and the multiagency discharge service and pathways, known locally as the Single Point of Access (SPA). The 2023-25 focus will be in on further enhancing the model using the Hospital Discharge increase funds to the Home First

pathway and to develop integrated teams that support the discharge of patients form hospital to home.

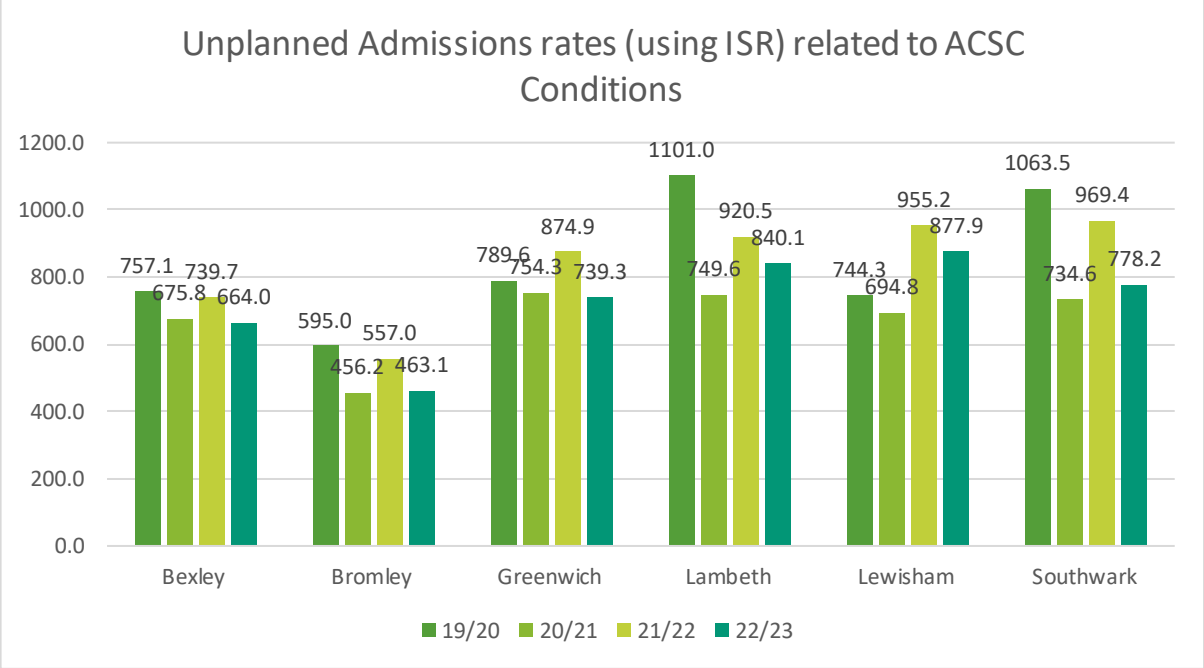
- Consolidate and continuously improve integrated urgent care pathways and effectively deploy BCF Winter pressure funding to manage seasonal demand. This includes consolidating 2 hour and same day health and care emergency services into a single Urgent Community Response (UCR) offer. (Note: UCR services are not currently funded by BCF.)
- BCF continues to fund Extra Care Housing Step-down provision with 3 additional digitally enabled step-down flats mobilised during 21-22. There are now 16 step-down beds.
- A Housing with Care Strategy to review and expand the provision of Extra Care Housing, Supported Living and other specialist housing to vulnerable adults – improving current stock and increasing supply in response to population led demand will be supported by BCF activity during the 23-25
- Significant BCF funding continues to fund the Integrated Community Equipment Contract, with a 2023-24 focus on to mobilising and embedding the recently procured new provider.
- Funding for investment in assisted technology from BCF has been steadily increasing. Through 23-25 the focus will be on continuing to increase the use of assisted technology across health and care services to help more people live in their own home – working with the Social Care Institute for Excellence (SCIE) on improving the user journey and outcomes through digital means
- The social care element of the proactive care pathway is be funded from the BCF. Through 2023-25 there is a commitment, through the ONE Bromley Strategy work, to further expand the Proactive Care pathway delivered through the local Integrated Care Networks, providing proactive care for people living with frailty to prevent deterioration and ensure people can live well until the end of their life. This is directly linked to the local implementation of the Fuller Review recommendations.
- Throughout 2023-24 review of BCF funding there will be a further focus on expanding the commissioning of closer to home services, building on the success of our hospital at home pilots – supporting more people in their own homes and or locating more services in primary and community care settings, e.g. Children's Integrated Hubs being piloted in two PCN areas to be expanded borough-wide – although not funded via BCF.
- Continued funding of integrated support to increase the take up of Direct Payments

In response to the policy shift for BCF and the development of the local 5 Year Strategy, a root and branch review of BCF activity and spend, alongside wider system investment, will be undertaken in Year one of the 2023-25 BCF Plan. The second year of the Plan will enable any transformation work to be undertaken to shift resources accordingly.

Condition 2: Enabling people to stay well, safe and independent at home for longer.

Positive progress is being made on supporting more people to stay well, safe and independent at home in Bromley, with some areas performing the highest in south-east London.

- There has been an ingoing increase in the use of Direct Payments (DP) to 24.9%, up from 18.3% in 21/22, enabling more people to purchase the care they want to meet their needs. A specific Direct Payments for Discharge project was launched in 2022-23, with ongoing focus to continue to increase the number of DPs as a key priority for the Council and the ICB.
- 43% of new adult social care service users who received a short-term service to maximise independence required no ongoing support or support of a lower level showing the positive impact in the short term intervention services offered locally.
- Residents living with frailty continue to be supported through the proactive care pathway via the Integrated Care Networks reducing and preventing deterioration
- There is an ongoing improvement in performance for the number of unplanned admissions to hospital for chronic ambulatory care sensitive conditions from 557 (As a rate per 1,000 of the population), to 463,1 in 22-23 outturn. Bromley continues to be the highest performing borough in SEL on this metric.



- As a result of the ongoing excellent community based support offered locally, the number of people aged 65 and over whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population has fallen year on year from 477.6 in 20/21 to 335.5 in 22/23, against a backdrop of an increase in the older population locally.

Demand and Capacity

The demand across community services has remained broadly in line with available capacity. Informed by detailed modelling, the current levels of demand in community services have, on the whole, been met through the commissioned capacity.

The voluntary sector offer, commissioned through BCF funding, continues to deliver a comprehensive range of prevention and early intervention services for local residents. Increased demand in some elements of this contract, namely the handyperson service has

been seen, resulting in a planned increase investment in this area during 23-24. The new expanded specification has been mobilised and includes additional resources and support to self-funders, carers and those living with long term conditions.

The demand for Reablement from the community continues to be broadly in line with capacity. Increasing the opportunities and offer of Reablement is a key priority and we expect to increase the number of eligible clients being referred from the community. An ongoing investment in Reablement from the BCF and planned further investment from the Hospital Discharge Fund will further increase the capacity of this service for both community step-up and hospital discharge, giving more people the chance to regain their daily living skills and independence for the best quality of life possible.

To date the occupancy rates across housing with care provision have ensured no waits for people accessing this offer from the community. However modelling shows occupancy rates are increasing alongside an increase in the older and vulnerable adult communities. Two comprehensive demand management projects looking at population trends for older people and for adults with a learning disability have informed the development of a Housing with Care Strategy. The council is soon to publish the strategy which will look to expand the Housing with Care market over the next 10 years, providing a vibrant and diverse housing with care offer to manage the increasing older and vulnerable adult population predictions, mitigating further demand or increase in the use of residential care. This includes some investment in the Extra Care Housing market in the 23-25 Plan, reflected in the hospital discharge section, whilst the wider Housing with Care Strategy is mobilised.

Bromley has a large care home market with 53 registered homes within the borough. The net number of beds has not changed significantly in the last year. However, there is an increase in the luxury market with a reduction in the number of quality, 'affordable' beds available to the Council. There are no instances where clients are required to access more restrictive care then needed. However, during peaks or surges in activity, there may be instances where clients have to wait longer than usual to access residential care and or be placed out of borough. Admissions to care homes from the community have continued in line with projections. The commissioned community offer and integrated working of community health and care teams, continues to enable more people to remain living at home. BCF funding invests in the brokerage service, to ensure sufficient capacity to the brokering of placements and to aid effective management of the market. The local Market Sustainability Plan is focusing on increasing the access to affordable, high quality residential care placements within the borough.

Bromley continues to be the highest performing borough in SEL against the BCF Metric for admissions for people with Ambulatory Sensitive Conditions, which continues to see a year in year improvement. Following the introduction of the Urgent Community Response (UCR) accelerator in 2019, alongside wider investment in integrated community services for people with long term conditions, admissions for ambulatory sensitive conditions have dropped from 2,079 in 19/20, to 1618 in 22/23.

The development of the hospital at home service locally will be a further enhancement to this offer with a focus on respiratory and frailty, the two areas of most activity locally. Although the UCR and integrated community pathways for people with long term conditions are not funded through the BCF, the BCF Funded Bromley Well VCS offer provides social support, advice and guidance for people with long term conditions and their carers. Furthermore, the

investment through the iBCF in social care provision as part of the Local Care Networks and Integrated Care Pathways, ensure clients requiring proactive and emergency access to social care to keep them well in the community is provided. All of which is contributing to reducing unnecessary attendances and admissions to hospital for local residents.

Local approach to enabling people to stay well, safe and independent at home for longer

The strengths-based 'Making Practice Personal', launched in 2020, is Bromley's approach to supporting people in the community through personalised enablement. This new model of practice was implemented with the support of the Social Care Institute for Excellence. The approach brings together practitioners, commissioners and providers to support the transformation of community based services. It is underpinned by the core concepts of the Care Act, ensuring community opportunities, citizenship and personalised outcomes. This systemic approach is underpinned by a culture change and learning and development programme to ensure sustainability with further activity planned with SCIE during 2023-24. The approach builds upon the positive progress made on delivering a strong 'Promoting independence' offer which brings together Reablement, local authority Occupational Therapy services and assisted technologies. The increase in BCF funding to support the use of assisted technologies is having a positive impact on assessment and keeping people safe, enabling people to remain at home living independently. The assisted technology infrastructure will continue to be expanded to reduce the dependence on care and support and will provide an infrastructure in which to utilise more technology across health and care services, including the virtual ward element of the hospital @Home service.

Integrated Care Networks (ICNs), locality based multidisciplinary teams designed to support residents with the most complex care needs to stay well, remain independent and out of hospital where possible, continue to go from strength to strength. Bringing together primary care professionals working to the PCN footprint, the ICNs are enabling people to stay at home with facilitated multi-professional interventions, providing more joined up care for residents. The ICB's current progress on, and initial plans for, developing neighbourhood working have received very positive feedback from Professor Clare Fuller.

Our work to develop the ONE Bromley Strategy highlights many areas of integrated working at a neighbourhood level, and recognises there is more opportunity to develop this further to optimise the wealth of community assets locally. The strategy priority programmes 2) Neighbourhood teams on a geographical footprint and 3) implement care closer to home programmes, will seek to continue to develop localised, integrated working that delivered personalised care, closer to home. Additional, priority programme 1) evidence driven prevention and population health, will support and inform the BCF review to ensure investment is being targeted to areas of evidenced need.

Therefore, during 2023-2025 we will

- Develop our new neighbourhood's approach to integration. This will include ongoing investment in integrated care networks and creating opportunities to further promote neighbourhood working, including developing the capability and capacity for changes with PCNs
- Continue to invest in voluntary sector, early intervention and prevention services including Reablement and Assisted technologies to support people to remain living safe

and well at home. Further increasing this investment and impact wherever possible including opportunities arising from the work with SCIE during 23-24.

- Invest Market Sustainability and Improvement Funds to support domiciliary care contract core providers to take on a larger share of clients, current performance is 28% against a target of 60 -70%
- Develop the trusted assessment role of domiciliary care providers to give greater flexibility and personalisation to help people stay at home
- Build on our progress in growing Direct Payments
- Strengthen and expand the support offer to unpaid carers through a new Carers' Plan and Carer's Charter
- Introduce a Housing with Care Strategy that, over time, will increase access to special housing and improve the current housing stock
- Further develop digital services with a focus on the customer experience and journey from accessing information, advice and guidance through to receiving care in the home

National Condition 3: Provide the right care in the right place at the right time.

In 2022-23 the Bromley Hospital discharge integrated system sustained excellent performance and outcomes including:

- 82% of residents were discharged on the day they no longer need to remain in an acute bed, with the majority of the remaining cohort being discharged the next day.
- 98% of clients receiving reablement/rehabilitation services remained at home 91 days after discharge
- All patients whose chosen place of death is home and were well enough to travel, were discharged home with excellent wrap around health and care to support them at the end of their life to die at home.
- Over 3,500 residents were supported through a broad and diverse voluntary sector offer that supports residents being discharged form hospital.
- The local rehab pathways were some of the highest performing in the country with clients achieving their rehab goals in an average of 22 days for bed based rehab against a national average of 26.6 days and 16 days for home based rehab against a national average of 24 days.
- Friends and family tests tell us 96% of residents receiving a Bromley Health Care Rehab service, would recommend them to a friend or family.

Bromley has continued to improve performance around the number of people being discharged to the normal place of residence BCF metric from 91.9% in 2019-20, to 94.3% in 2022-23. The highest reason currently for patients not being discharged to their normal place of residence, as per the table below, is due to patients being discharged to 'NHS run care home' accounting for 2.6% and patients being 'discharged to another NHS hospital provider – ward for general patients or the younger physically disabled' accounting for 1.8%. Given the demographic of the population, the local priority is to increase the opportunity for residents to receive rehab or a period of convalescence in a non-acute setting, or for patients to be seen in the most suitable environment to meet their needs including being transferred to another NHS setting, therefore discharges to another setting in both of these categories are deemed appropriate. Discharges to a care home straight from hospital have reduced from 72 in 21-22 to 64 in 22-23, with aspirations to reduce this further in 23-24 through the mainstreaming of the Home First model, which is planned to be funded through the Hospital Discharge monies.

Spells	Financial Year				
Discharge Destination	2019/2020	2020/2021	2021/2022	2022/2023	Grand Total
Usual place of residence unless listed below	26,477	23,015	25,721	21,757	96,970
NHS run care home	637	684	735	681	2,737
NHS other hospital provider - ward for general patients or the younger physically disabled	480	474	491	449	1,894
Temporary place of residence when usually resident elsewhere (includes hotel, residential educational establish	306	270	230	170	976
Not known: a validation error	439	43	34	58	574
Non-NHS (other than Local Authority) run care home	64	53	72	64	253
Non-NHS (other than Local Authority) run Hospice	50	50	53	65	218
Not applicable - hospital provider spell not finished at episode end	70	52	40	54	216
NHS other hospital provider - ward for patients who are mentally ill or have learning disabilities	61	48	52	31	192
Non-NHS run hospital	58	35	34	31	158

Demand and capacity

Demand and Capacity for hospital discharge is closely monitored and scrutinised through the Bromley Discharge System Quality Assurance and Performance Management Framework, which is managed through a monthly performance surgery attended by health and care leads and reported to ONE Bromley Executive on a quarterly basis. The integrated discharge function, delivered through the SPA, allows services to be flexed to respond to changing needs of residents throughout the year as well as balancing capacity and demand. Residents are never offered support in a more restrictive setting. Instead health, social care and VCS services are used flexibly to wrap around the needs of the clients, co-ordinated and managed by the Bromley SPA.

Capacity was able to meet demand throughout 2022-23 with clients being discharged into the least restrictive setting possible and all hospital discharge pathways working to a strength based, reablement and recovery ethos. All clients are offered the opportunity to receive rehab or reablement where they meet the criteria, with aspirations to further increase this offer for a wider client cohort during the 2023-25 BCF Plan period. Bromley supported discharges average 875 per quarter with 82% being discharged to pathway 1, 11% to pathway 2 and 7% to pathway 3.

Hospital discharge activity remains broadly consistent throughout the year with an increase in activity and pressure seen during the winter months. The BCF winter funding is used successfully to increase discharge capacity during the winter period, directed by the ONE Bromley Winter Plan which uses as an evidence-based approach to inform winter planning. This will continue throughout the 2023-25 BCF Plan ensuring winter planning and delivery continues to meet local need.

The Discharge to Assess domiciliary care market, which accepts discharges 7 days per week, continues to keep up with demand and also provides capacity to support other pathways where demand is an issue (often caused by staff sickness.) No resident remains in hospital once they are medically fit to leave. Packages of Care (POC) can be arranged and started within 2 hours, providing a robust and responsive offer to hospitals for the discharge or patients.

The Extra Care Housing Discharge to Assess flats have seen a steady throughput with no clients waiting for ECH provision throughout the year. ECH step down accommodation, which is funded through BCF, is also used when a resident is unable to return home temporarily due to maintenance or environmental factors, to enable the client to still be discharged and supported in an independent environment. The 2023-25 Plan aims to further align ECH step down to the SPA to further develop integrated working for clients on this pathway which will expand the range of residents that are able to be supported via Extra Care Housing from hospital, reducing the potential admission to a residential placement. Further expansion of this pathway, with 3 fully connected assisted technology flats funded through hospital discharge monies will support the expected increase in demand as a result of these changes during 2023-24.

Of the pathway three discharges to a placement, 20% are for patients rapidly dying funded under the Fast Track framework or Continuing health Care eligible patients, 41% are for people self-funding their care and the remaining 39% are clients being supported under the adult social care discharge to assess pathway. Pathway three is the only pathway where

there are some delays driven by market availability and/or specialist or complex needs of clients which require a certain environment or skill to manage. The system works hard in these situations to identify and work with providers to achieve the discharge, into a setting that can meet the client's needs. Further work to develop in-borough capacity that can support behaviours that challenge is planned as part of the 2023-25 Plan using Hospital Discharge monies, alongside wider market development activity as part of the adult social care reform.

High Impact Change Model

11%[1] of BCF funding is used to deliver against the High Impact Change Model (HIC) for hospital discharge with all but 1 of the 9 High Impact Change areas achieved. Several areas are delivering at an exemplary level including 'Monitoring and responding to system demand and capacity' and 'multi-disciplinary working'. The further investment of the Hospital Discharge money will take the delivery of Home first and 7 day working from the current 'achieved' to exemplary through the 23-25 Plan.

Further work on the utilisation of the DFG to achieve HIC 9: Housing and related services will be a key priority during 23-25 to ensure this objective is achieved during the plan period.

Impact change	Progress
Change 1: Early discharge planning	Achieved
Change 2: Monitoring and responding to system demand and capacity	Exemplary
Change 3: Multi-disciplinary working	Exemplary
Change 4: Home first	Achieved -working towards Exemplary
Change 5: Flexible working patterns	Achieved -working towards Exemplary
Change 6: Trusted assessment	Achieved
Change 7: Engagement and choice	Achieved
Change 8: Improved discharge to care homes	Achieved
Change 9: Housing and related services	Not yet met

Investment in Hospital Discharge

There continues to be an ongoing and increasing investment form the BCF in hospital discharge services. The named Hospital Discharge Lead and Hospital Discharge co-ordinater, as required by the Hospital Discharge Guidance, are joint funded through BCF, with overall responsibility for hospital discharge across the partnership. This joint leadership continues to deliver strong management and leadership to maintain discharge performance and quality locally and leads ongoing transformation work associated with hospital discharge. This single oversight ensures the system can monitor and respond to pressures,

[1] Not including investment in Discharge to Assess (D2A) services

whilst also ensuring there is no negative impact on any single organisation's finances or resources as a result of hospital discharge activity.

Supporting unpaid carers

Unpaid Carers

The 2021 census identified c.25,000 unpaid carers in Bromley – a drop on previous census results most likely explained because the census took place at the time of lockdown when many caring arrangements were disrupted. Around 4,000 carers are registered with the local Carers' Support Service with c. 9,000 carers registered with GPs.

The local dedicated Carers Support Service was recommissioned in 2022 with Bromley Well and is funded through BCF.

BCF funds enable the following short break and other respite services

- Bromley Dementia Support for people diagnosed with dementia and their carers, including people with early onset dementia.
- Bromley Respite at Home services provides family carers with a break from caring and engages people in activities to help them maintain everyday living skills.

Other Council funding enables a broad respite offer including direct payments to access community services, day services and residential short breaks. A respite and short breaks offer to adults with a learning disability includes a dedicated respite centre including planned and unplanned residential respite along with a menu of community based and home sitting options.

Carers who access the support arrangements report high levels of satisfaction. The National Survey of Adult Carers in England undertaken by NHS England national carers' survey reports for Bromley that:

- 36% of carers were extremely or very happy with the support and services from social services for either the carer or the person cared for
- 71% of carers always or usually felt involved in discussions about support for the person they cared for

However we want more carers to know what support is available through raising awareness of the offer with professions and with residents.

Consultation and coproduction with unpaid carers highlights the following areas for improvement.

- Information, advice and guidance should be more consistent across the agencies that carers go to get their support
- GPs and other health workers are often seen as the first source of advice and could provide more information and advice and signpost carers to the best help from other agencies
- Care and health professionals could share more information with carers on the residents they are caring for
- Care and health workers undertaking assessment should learn more about the lived experience of being a carer
- Clearer information and advice is needed on what respite support is available
- Support to develop long-term and emergency plans would reduce anxiety about situations when carers may be unable to provide care.'

Young carers said:

- Help with education support should be more consistent across schools and college
- At secondary school teachers should know about their young carers' responsibilities and take this into account.

The Council and ICB have developed a new and joint Carers Plan and this will be formally agreed in 2023. The Plan has been informed through consultation events with over 100 unpaid carers, including young carers and draws upon the biennial NHSE survey and other data.

The priorities for the new Plan in 2023-2025 are:

- Identifying, recognising and involving carers
- Making clear routes to information, advice, guidance and support
- Supporting carers' physical health and wellbeing
- Supporting carers to have a life alongside their caring role
- Supporting young carers and young adult carers

A key action in the Plan is the development of a Carers' Charter by the ONE Bromley partnership that will develop a clear and consistent advice and support offer to unpaid carers and support to staff in working to help carers.

Disabled Facilities Grant (DFG) and wider services

There is an undersupply of fully accessible homes to meet demand. This is being addressed in three ways. Firstly, by ensuring through planning conditions that new developments include a proportion of accessible homes, secondly by adaptation of existing homes, and thirdly by ensuring that our own programme of new build developments contains a proportion of accessible homes.

Our approach recognises that adaptations have a critical role in:

- supporting older people, disabled people, young disabled children 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 and other hazards 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

The Council has two specialist Housing Occupational Therapists. Their role is threefold. They assess the needs of Housing Register applicants that require Accessible/Adapted

housing; they assess the accessibility and adaptability of void properties so they can be successfully matched to the needs of applicants, and; they inform the process of new build developments to ensure accessible properties are built to correct standards.

We have improved liaison between Housing Services, OT, and Social Care via joint working at a senior level to ensure needs of high profile cases are met. We also improved liaison with health around hospital discharge through relationships and pathways developed in response to the Covid pandemic.

Within the Council a monthly High Need Cases Panel ensures the best use of available housing resources and to ensure that we can respond quickly to changes in circumstances. This year we also plan to introduce quarterly reviews of high need cases across Housing, Social Care and OT.

The Council is reviewing its approach to housing improvement in line with the Statutory Guidance on DFG delivery issued by DLUHC, RCOTs guidance adaptations without delay and internal policy consultation with partners and residents. We are in the process of developing our local Housing Assistance Policy as allowed for under the Regulatory Reform (Housing assistance) Order. Giving greater flexibility in supporting the wider housing and health hazards arising in peoples home often resulting in hospitalisations. The new policy will deliver a suit of grants and loans outside of the mandatory guidelines cantered on housing and health. To achieve this we have had extensive discussions with our housing and enforcement colleagues to ensure the grants are targeted to achieve the best possible outcomes. We are also address within this policy the lack of adapted and adaptable properties by working with our social registered providers to ensure properties being disposed of by RSLs at auction due to repair cost are kept within the social sector where these properties are suitable for adaptation. The new policy will help take forward the spend of accrued funds.

Our policy will include top up and discretionary funding to Mandatory DFG and include grants for energy efficiency, eradication of Cat 1 hazards as described by the Housing Act 2004 and Nuisance as Described in the Environmental Protection Act 1990.

There will be a landlord element to bring back empty properties and security and safety and to ensure Minimum energy efficiency standards are met as well working with them to ensure their homes are adapted where they have tenants requiring this.

Additional information (not assured)

Have you made use of the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO) to use a portion of DFG funding for discretionary services

Yes

If so, what is the amount that is allocated for these discretionary uses and how many districts use this funding?

£3M

Equality and health inequalities

Demographic Profile

The update of the demographic profile for our Joint Strategic Needs Assessment (JSNA) made in 2021 has highlighted the following issues 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 2020/21) prevalence of learning disabilities is 0.3%, approximately 1191 people.

NHS Health Check Equity Audit- Years 2018, 2019-20 and 2021-22

The Council's Public Health Service has conducted a series of audits on equity for NHS checks. The key areas examined were number (%) of eligible people invited for NHS Health Checks, number (%) of checks completed and any differences by age, gender, ethnicity and GP practice.

Results of these audits are positive, particularly in that we have consistently not found an inequity in terms of ethic groups. Also, there has been an improvement in the proportion of younger people (45-54) completing the check. However, the variation between the GP practices has not improved over time.

Actions following the audits have included engagement with GP practices – Public Health nurses visited individual practices and discussed their specific issues. Support and advice were offered to several practices. Further engagement and training will be provided to GP practice as well as continuous support.

Health Inequality Projects

ONE Bromley 5-Year Plan health inequalities priorities including priority actions for Core20PLUS5 include the following schemes that commenced in 2022-23.

Orpington and Crays Frailty Hubs/Cafes – Designed with local residents services include cafes, social activities, healthcare talks and healthy food working. Health checks at the cafes are identifying patients with underlying conditions who have previously not been known or engaged with healthcare services. The learning from these pilots is informing the introduction of similar hubs across the Borough.

Homeless Project - An integrated team, including the GPs, mental health services, drug and alcohol services, are running healthcare clinics for people in the local Homeless Shelter. The project is addressing the health inequalities and barriers to accessing health services faced by this population. The service is now operational with outcomes being measured.

Pro-active Care Case Management Pilot - Care for patients who have been pro-actively identified, include high-users of healthcare with complex needs. A case management team ensures that actions are followed up from a holistic review. Once completed, these patients are handed back into the care of their GP practice and a Care Navigator. The outcomes being monitored are reduction in the patients immediate health and care needs across the system, such as a reduction in escalation to hospital emergency and elective services. Patients have now been identified and are under the care of the case management team. The learning from this pilot will be used to inform models on a Borough wide basis.

PCN Housebound patients projects - These projects reach out to these patients, identifying this most at risk and visiting the patients at home to review their needs. This results in reducing the social inequalities for this cohort of patients who are generally more isolated and improving their health outcomes and chronic disease management.

In 2023-24 new health inequalities projects will include establishing of a Health and Well Being Hub in the Bromley Town Centre Shopping Centre, offering vaccinations, NHS Health Checks, signposting to screening, cost of living advice and health and lifestyle advice.

Bromley Health & Wellbeing Strategy 2024 – 2030

Work began in 2022 on preparing the Borough's new Health and Wellbeing Strategy for implementation from 2024. The Health & Wellbeing Board has agreed the following three overarching priorities to inform this work:

1. Improving Health and Wellbeing of young people (to include obesity, youth violence, adolescent mental health).

2. Improving Health and Wellbeing of Adults (to include obesity, diabetes, dementia, mental health, substance misuse).

3. Disease prevention and helping people to stay well (linking with our ICB prevention priority and achieving this through our vital 5 work).

The strategy and its action plan will be completed in time for 2024.