Report No.
ACH24-008

London Borough of Bromley

PART ONE - PUBLIC

Decision Maker:	**Health and Wellbeing Board (HWB)**
Date:	**Thursday 8th February 2024**
Decision Type:	Non-Urgent Non-Executive Non-Key
Title:	**Better Care Fund Q3 (23/24) Performance and Finance Report**
Contact Officer:	Name: Ola Akinlade Integrated Strategic Commissioner Tel: 0208 313 4744 E-mail: ola. akinlade@bromley.gov.uk
Chief Officer:	Kim Carey, Director of Adult Social Care, London Borough of Bromley Angela Bhan, Managing Director, Bromley Clinical Commissioning Group
Ward:	All Wards

1. Reason for decision/report and options

This report provides the Health and Wellbeing Board with an overview of Bromley's performance against the Better Care Fund and the Improved Better Care Fund metrics and an update on expenditure and activity for the reporting period detailed below in Section 3. The report also provides an update on the key activities of the Bromley Better Care Fund 2023-25 Plan in the appendix.

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2. RECOMMENDATION(S)

The Health and Wellbeing Board is asked to note:

2.1 Performance against BCF metrics and BCF planning priorities for the reporting period.

2.2 BCF spend for the reporting period (October to December 2023)

Impact on Vulnerable Adults and Children

1. Summary of Impact: Summary of Impact: There is no negative impact. The services support both the local Corporate Plan priorities and statutory duty

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Transformation Policy

1. Policy Status: Existing Policy
2. Making Bromley Even Better Priority:

    - For adults and older people to enjoy fulfilled and successful lives in Bromley, ageing well, retaining independence, and making choices.
    - For people to make their homes in Bromley and for business, enterprise and the third sector to prosper.
    - To manage our resources well, providing value for money, and efficient and effective services for Bromley's residents.

Financial

1 Cost of proposal: BCF: £29,703k; iBCF: £7,730k; DFG: £2,967k
2. Ongoing costs: BCF: £29,703k; iBCF: £7,730k; DFG: £2,967k
3. Budget head/performance centre: Better Care Fund
4. Total current budget for this head: £40,400k
5. Source of funding: Better Care Fund, Improved Better Care Fund, Disabled Facilities Grant

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Personnel

1. Number of staff *(current and additional)*: N/A
2. If from existing staff resources, number of staff hours: N/A

Legal

1. Legal Requirement: Statutory Requirement
2. Call-in: N/A

Procurement

1. Summary of Procurement Implications: N/A

Property

1. Summary of Property Implications: N/A

Carbon Reduction and Social Value

1. Summary of Carbon Reduction/Sustainability Implications:

Impact on the Local Economy

1. Summary of Local Economy Implications: N/A

Impact on Health and Wellbeing

1. Summary of Health and Wellbeing Implications: The Better Care Fund provides an opportunity to transform local services so that people are provided with better integrated care and support. It

encompasses a substantial level of funding to help local areas manage pressures and improve long term sustainability. The Fund will also support the aim of providing people with the right care, in the right place, at the right time, including through a significant expansion of care in community settings.

Customer Impact N/A

1. Estimated number of users or customers *(current and projected)*: N/A

Ward Councillor Views

1. Have Ward Councillors been asked for comments? N/A
2. Summary of Ward Councillors comments: N/A

3. COMMENTARY

3.1 The Better Care Fund (BCF) Policy Framework sets out the Government's priorities for 2023-25, including improving discharge, reducing the pressure on Urgent and Emergency Care and social care, supporting intermediate care, unpaid carers, and housing adaptations. In Bromley, the BCF grant is ring fenced for the purpose of pooling budgets and integrating services between Southeast London Integrated Care Board (Bromley) (SELICB) and London Borough of Bromley (LBB). The Improved Better Care Fund (iBCF) was a funding element added to the Better Care Fund from 2017-18 paid to the Council as a direct Local Authority grant for spending on adult social care.

Since 2015, the BCF has been crucial in supporting people to live healthy, independent, and dignified lives, through joining up health, social care, and housing services seamlessly around the person. This vision is underpinned by 2 core objectives, to:

- enable people to stay well, safe, and independent at home for longer.
- provide people with the right care, at the right place, at the right time.

The BCF achieves this by requiring integrated care boards (ICBs) and local government to agree a joint plan, owned by the health and wellbeing board (HWB), governed by an agreement under section 75 of the NHS Act (2006). This continues to provide an important framework in bringing local NHS services and local government together to tackle pressures faced across the health and social care system and drive better outcomes for people.

3.2 As detailed in the BCF 2023-25 Submission Report to Bromley HWB (ACH23-032), NHS England made significant changes to BCF Planning requirements including the introduction of a 2-year plan (2023-25) and the measuring of an additional Metric (Falls). The report detailed below provides, where data and information are available, an update on Bromleys performance against BCF metric targets and the current financial position.

3.3 Update on Bromley performance against BCF Metrics

The reporting period covered for each of the metrics in terms of targets and performance detailed in Table 1 below. This table provides an update on Bromleys current performance (where the data is available) against the 23-25 performance metrics.

Table 1: BCF Metric Targets and Bromleys current performance

BCF Metric Description	Bromley BCF Targets for 2023-24	Target for period detailed below	Actual for period detailed below	Comments/ Mitigation
Avoidable admissions: *Indirectly standardised rate (ISR) of admissions per*	440	220 (M[2]1-M6)	273[3] (M1-M6)	The aim of this metric target is for performance to be below or equal to 220 admissions for the reporting period (M1-6). Bromleys performance (M1-6). is 272. This is higher than projected however there was a 19% improvement in AA performance between Q1 and Q2 of the period.

[2] M means Month.
[3] Unplanned ACSC Admissions Report (sharepoint.com)

100,000 population [1]				An upward trajectory in this indicator is due to an increase across respiratory conditions mainly, with a small increase in Anaemia, Angina and Epilepsy. There are relatively high levels of people aged 60 and above being admitted for these conditions (for COPD this is mainly those aged 60 and over, for Angina this is amongst those aged 65 and over while for Anaemia this is amongst those aged between 35 and 55 and aged 75) **Mitigation:** • Good utilisation of Bromley Hospital at Home by hospital same day emergency care services, avoiding admission, especially for frail, diabetic, COPD and heart failure patients. • Go-live of proactive care pathway expansion pilot for greater follow-up with chronic patients. • 1st workshop (diagnostic phase) for establishing integrated diabetes service with Primary Care Networks to support improvement against diabetes 8 care processes and 3 treatment targets. Health Innovation Network supported.
Falls *Emergency hospital admissions due to falls in people aged sixty-five and over directly age standardised rate per 100,000*[4]	2097.8	1048.5 (M1-M6)	995[5] (M1-M6)	The aim of this metric target is for performance to be below or equal to 1048.5 for the reporting period. (M1-M6) Bromleys performance (M1-6). is 995 with a 5% improvement from Q1 to Q2 performance. **Mitigation**: Some work is being done to reconcile the figure reported locally through the Southeast London BCF Dashboard with NHS England figures detailed in the BCF report template.
Discharge to usual place of residence *Percentage of people in the HWB who are] discharged from acute hospital to their normal place of residence*	93.5%	93.5% (M1-M7)	93.96 %[6] (M1-7)	The aim of this metric target is for performance to be or exceed 93.5% of people discharged from an acute setting to their usual place of residence. Bromleys performance for the period (M1-M7) is 93.96% **Mitigation**: None required
Residential Admissions *Long-term support needs of older people (age 65 and over)*	366.1	244 (M1-M8)	(M1-M8) 239.4	The aim of this metric target is for our performance on residential admissions to be less than or equal to 244 for this reporting period (M1-8) Bromleys performance for the period is 239.4 which demonstrates that Bromley is hitting the target for this metric. **Mitigation**: None required

[1] 2.3.i Unplanned hospitalisation for chronic ambulatory care sensitive conditions - NHS Digital
[4] Public Health Outcomes Framework - Data - OHID (phe.org.uk)
[5] BCF Dashboard (sharepoint.com)
[6] BCF Dashboard (sharepoint.com)

Reablement *Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services.*	96.5%	96.5%	98.2 (M1-M4)	As there is a 91-day lag in measuring Reablement Performance data is available for April to July 2023 only. This shows that Bromleys performance is at 98.2 % Mitigation: none required

Overall, Bromley continues to perform well against the BCF 23-24 metric targets for the reporting period covered. Bromley, however, continues to exceed the maximum projected levels of Avoidable Admissions for the period covered (M1-M6)) as the levels of admissions for ambulatory care sensitive conditions continue to increase. There has been an improvement in performance for Q2 compared to Q1 and mitigating actions are also being implemented to address this (detailed in Table 1)

3.4 Update on progress made against BCF Plan for Q3 2023-24

The detail below (as well as information in Appendix A) provides an update with regards to Bromleys progress against our priorities as detailed in our Better Care Fund 23-25 plan and demonstrates that good progress is being against the plan for Q3 of this financial year (2023-24)

3.5 BCF National Condition 1-Approach to integration

BCF National Condition 1 requires BCF Plans to be agreed by the ICB(s) (in accordance with ICB governance rules) and the local council Chief Executive, prior to being signed off by the HWB. Within the BCF 23-25 plan, the partnership is also required to demonstrate s75 pooled budgets and have a strategic approach to delivering the objectives of the BCF. Bromley's 23-25 plan submission clearly sets out the strategic approach and key projects that exemplify and demonstrate our approach to progressing integration across health and social care.

3.6 BCF National Condition 2 -Enabling People to stay well and stay independent.

National Condition 2 requires areas to agree how the services they commission will support people to remain independent for longer, and where support them to remain in their own home. The actions required to meet BCF Condition 2 are detailed in Appendix A of this report and show good progress being made against these actions.

3.7 National Condition 3 -Provide the right care at the right time.

National Condition 3 requires areas to agree how the services commissioned will support people getting the right care at the right time, including through the supporting of safe and timely discharge. A summary of key activities is detailed in Appendix A of this report and show good progress being made against these actions.

3.8 DFG

A key area of focus for DFG is the development of the Housing Assistance Plan 2023-25. Key actions include.

- The development of the DFG discretionary grant
- Reviewing the links between Housing and Health provision
- Fast tracking the processing of grants
- Review of Housing Hazards

Good progress is being made against these actions and is further detailed in the appendix.

3.8 Health Inequalities

LB Bromley Public Health are overseeing a range of initiatives including.

- Collaboration between Orpington PCN and Healthcare
- Expansion of the Well Being café
- Co-design of asset mapping within the community
- Developing a Homelessness Health project

Good progress is being made against these actions and is further detailed in the appendix.

4 IMPACT ON VULNERABLE ADULTS AND CHILDREN

All services are targeted at vulnerable adults with a focus on avoiding people who are vulnerable reaching the point of crisis where they would be seeking support of statutory services and/or requiring an unplanned admission to hospital. Funds also enable the supported discharge of patients from hospital into the community.

5 FINANCIAL IMPLICATIONS

5.1 The 2023 – 2024 Better Care Fund Plan, including Disabled Facilities grant and the improved Better Care Fund, is set out in the table below. At this stage in the financial year, the only forecast variance is a projected underspend of £818k on the Disabled Facilities grant-funded schemes.

5.2 The Better Care Fund Minimum NHS contribution has been uplifted by 5.66% for 2023/24 from 2022/23 and is assumed to be uplifted again by 5.66% for 2024/25. The allocation between schemes is likely to change during the year in respond to service pressures and will be reflected in future reports to the Health & Wellbeing Board.

5.3 On 7 September 2023, the Government announced £50m of additional funding for the Disabled Facilities Grant in 2023-24. Bromley has been allocated an additional £213k, which is reflected in the table below.

5.4 Any underspends or unallocated amounts on each project can be carried forward into the next financial year. Quarterly reports are required by government to show the progress of the BCF/IBCF schemes.

		Scheme Type	Scheme Name	2023/24 Plan Expenditure £'000	2023/24 Forecast £'000	Forecast variance £'000
BCF Minimum ICB Contribution and Hospital Discharge Funding						
	ICB	Assistive Technologies and Equipment	Assistive Technologies	609	609	0
	LBB	Assistive Technologies and Equipment	Assistive Technologies	480	480	0
	ICB	Bed based intermediate Care Services	Intermediate Care Services	1,446	1,446	0
	LBB	Bed based intermediate Care Services	Intermediate Care Services	1,338	1,338	0
	ICB	Carers Services	Support for carers	599	599	0
	ICB	Community Based Schemes	Risk pool	1,532	1,532	0
	Joint	Enablers for Integration	Community and Social Care Development Fund	1,088	1,088	0
	LBB	Enablers for Integration	BCF Post	43	43	0
	LBB	Enablers for Integration	Learning Disabilities	27	27	0
	ICB	High Impact Change Model for Managing Transfer of Care	Risk pool	641	641	0
	LBB	High Impact Change Model for Managing Transfer of Care	Risk pool	56	56	0
	ICB	Home Care or Domiciliary Care	Improving healthcare services to Care Homes	357	357	0
	LBB	Housing Related Schemes	Improving healthcare services to Care Homes	475	475	0
	ICB	Integrated Care Planning and Navigation	Assistive Technologies	430	430	0
	LBB	Integrated Care Planning and Navigation	Assistive Technologies	61	61	0
	ICB	Personalised Care at Home	Personalised Support/care at home	705	705	0
	ICB	Personalised Care at Home	Reablement services	1,082	1,082	0
	LBB	Personalised Care at Home	Protecting Social Care	11,284	11,284	0
	LBB	Personalised Care at Home	Dementia Universal support service	592	592	0
	LBB	Prevention / Early Intervention	Support for carers/assistive technology	1,910	1,910	0
	LBB	Reablement in a persons own home	Reablement services	1,327	1,327	0
	LBB	Home Care or Domiciliary Care	Discharge to Assess	702	702	0
	LBB	ASC Discharge Fund	Discharge to Assess	1,001	1,001	0
	ICB	ASC Discharge Fund	Discharge to Assess	1,511	1,511	0
	LBB	Enhanced Care	Discharge to Assess	207	207	0
	ICB	Staffing contribution	ICB staffing contribution	200	200	0
				29,703	**29,703**	**0**
DFG						
	LBB	DFG Related Schemes	Disabled Facilities Grants	2,967	2,149	-818
				2,967	**2,149**	**-818**
iBCF						
	LBB	Assistive Technologies and Equipment	Equipment	214	214	0
	ICB	Enablers for Integration	D2A staffing	95	95	0
	LBB	Home Care or Domiciliary Care	D2A DomCare	321	321	0
	LBB	Home Care or Domiciliary Care	DomCare	72	72	0
	LBB	Home Care or Domiciliary Care	Whole system reserve	1,677	1,677	0
	LBB	Personalised Budgeting and Commissioning	Reducing pressures	4,863	4,863	0
	LBB	Residential Placements	D2A Placements	83	83	0
	LBB	Residential Placements	Placements	405	405	0
				7,730	**7,730**	**0**
Grand Total				**40,400**	**39,582**	**-818**

6 LEGAL IMPLICATIONS

6.1 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.

6.2 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).

6.3 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.

6,4 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

6.5 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.

6.6 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

7 PROCUREMENT IMPLICATIONS

The current BCF programme is funded for 2 years commencing April 1st, 2023, and ending March 31st, 2025.

8 IMPACT ON HEALTH AND WELLBEING

The Better Care Fund provides an opportunity to transform local services so that people are provided with better integrated care and support. It encompasses a substantial level of funding to help local areas manage pressures and improve long term sustainability. The Fund will also support the aim of providing people with the right care, in the right place, at the right time, including through a significant expansion of care in community settings.

Non-Applicable Headings:	[List any of headings 4 to 15 that do not apply.]
Background Documents: (Access via Contact Officer)	[List any documents used in preparation of this report - Title of document and date]

Appendix A - **BROMLEY BETTER CARE FUND 2023 TO 2025: PROGRESS REPORT ON KEY ACTIONS**

National Condition 1: Overall BCF Plan and Approach to Integration

Summary:
The Bromley Local Care Partnership signed off on the Bromley 5-year Plan for care and health in June 2023. With the three priorities:

- Improve population health and wellbeing though prevention and personalised care.
- High quality care delivered closer to home delivered through our neighbourhoods.
- Good access to urgent and unscheduled care and support to meet people's needs.

Progress on actions to support the delivery of these objectives are detailed below:

Threaded through the delivery of each of these priorities is the development of neighbourhood working, as recommended in the Fuller Report, and representing a further expansion of our multi-disciplinary working across One Bromley organisations.

Integrated neighbourhood teams, on geographic footprints across the borough, offer us the opportunity to reduce duplication between our own services, better facilitate residents when their care and support requires input from multiple organisations and ultimately drive efficiency.

Evidence from around the world also points to more connected neighbourhood populations being more resilient, having better health and life outcomes and greater independence. We therefore plan that our emerging integrated health and care neighbourhood teams are well aligned with, connect, and support the local population they serve and are a part of.

Our development approach is to shape existing multi-agency working with communities across care, health, and the voluntary sector into a more formalised neighbourhood approach. This includes:

- Using local and borough insights in care and health prevention and population health to deliver programmes which are co-developed with residents and respond to local needs in ways which resonate with the relevant community.
- Integrating primary care services – utilising specialists in mental health, pharmacy, therapies, and others across in primary care networks as part of a wider programme to secure the future of general practice.
- Acknowledging that innovations mean we can work across agencies to move more care out of physical and mental health hospitals into communities and even into people's own homes.
- Develop an urgent and emergency care model across voluntary, primary, mental health and acute physical providers which is more intuitive for residents and better meets their needs.

Review of Better Care Fund spend	The Council's Finance Manager (Adult Social Care, Health & Housing) is leading a detailed review of the BCF spend. Much of the BCF spend is historical and as the policy agenda has developed, ensuring this spend is aligned to local strategic priorities and delivering good value for money is essential.
Neighbourhood teams	The One Bromley Executive have agreed the approach to developing neighbour hoods. Next steps are focused on the initial stages for delivery across care and health partners. This work requires bringing secondary care, social care, community care, mental health, primary care and voluntary and third sector together in focussing on the health and care needs of a geographic place – either as part of a core integrated neighbourhood team or dovetailing with those teams Immediate next steps are focused on establishing governance and enablers to support existing work to deliver in a 'neighbourhoods' approach as well as establishing core Integrated Neighbourhood Teams. This includes work across the partnership and with communities to build on some of the existing foundations that are in place - for example all adult social care, specialist palliative care and district nursing have arranged themselves around PCN boundaries. The aligns with the development of core integrated neighbourhood teams around specific populations groups within a locality
Evidence driven prevention and population health	A strategy is being developed by the One Bromley Executive for agreement. A key aspect of this work is to provide the necessary insights and analysis to support borough-wide and more local programmes delivered at a neighbourhood level.
Primary care sustainability	This work is being developed as workstream within the wider Fuller Review implementation for integrating primary care services
Implement care closer to home programmes	The Adult and Childrens and Young Peoples' Hospitals at Home services continue to expand in their offer of acute level care at home. Referrals are now open to all GP practices as well as the hospital and urgent community response services. The adult service has expertise in remote monitoring, respiratory, frailty,

	urgent palliative, and intravenous care to avoid hospital attendance, avoid admission to hospital and shorten hospital stays. Both services are exemplar in their field for integrated working offering single points of access for referrers.
Integrated urgent care	Within our Joint Forward Plan, SEL has made a commitment to deliver an integrated safe and responsive urgent and emergency care model that meets population needs, is intuitive to patients, and enables people to access the care they need, in the least intensive setting possible. This aligns with the national policy agenda including the Fuller Review which pushes us to completely untangle the current way same day care is delivered from multiple providers into a more streamline offer that make sense to residents. A key delivery opportunity for this is provided in the procurement of the 111 Integrated Urgent Care Service, commonly known as the 111 Service which offers an enormous opportunity for SEL to develop a more localised 111/same day care service that meets the needs of SEL residents by integrating into local neighbourhood-based teams versus being a separate stand-alone service as it currently is. The 'new' 111 same day care service is due to go live in September 2025, however due to the scale of the procurement, defining the new model of care is required by February 2024. Bromley have embarked on a range of engagement opportunities to understand the challenges in the current delivery model for both clinicians and residents, and has been working alongside SEL boroughs to develop a more localised delivery model for same day care

National Condition 2: Enabling People to Stay Well, Safe, and Independent at Home for Longer

Summary:
National Condition 2 requires areas to agree how the services they commission will support people to remain independent for longer, and where possible support them to remain in their own home. The challenges our borough faces regarding independence span physical and mental health. Alongside the actions documented below, as our neighbourhoods work gathers pace, this Condition will be further supported by increasingly well-connected communities. This is well evidenced across the world as driving resilience, improved quality of life and often improved longevity of life.

Progress on current actions to support the delivery of these objectives are detailed below.

Invest Market Sustainability and Improvement Funds to support Domiciliary Care Patch Providers to continue to expand their new services and deliver 60%-70% of packages of care in their geographical area.	Agreements over funding and support arrangements are being made over September and October 2023 – 100% of packages of care are being meet currently either via the Patch, Framework or decreasingly via spot providers. The Patch providers will receive incentives and support to enable them to recruit more staff so that greater numbers of clients receive a lead provider package of care.
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.	This work is still being developed and discussions are being had with regards to opportunities to link prevention and early intervention work to reablement and assisted technologies to support people to remain independent at home.
Develop the Trusted Assessment role of domiciliary care providers to give greater flexibility and personalisation to help people stay at home.	The Dom Care team are currently seeking to recruit a Trusted Assessor project officer/social worker role. This will support adults social care to initiate the project. The high-level outcomes are to reduce packages of under £101 per week where it is safe to do so. We will work with care providers to achieve this via incentives.
Build on our progress in growing Direct Payments	Performance as of October 2023 is 24.85%, 2.15% short of 27% Target. The Integrated Commissioning Service will continue to take steps to mitigate this risk including accelerating the recruitment of PA's via linkmeup register and the development of bespoke adverts
Strengthen and expand the support offer to unpaid carers through a new Carers' Plan and Carer's Charter	A new Carers Plan was agreed by the Council's Executive in September 2023. Work, led by Bromley Well, to develop the Carers Charter has focused on consultation with carers and carer representatives over the Summer. An application for DHSC Accelerator Funds to support unpaid carers at the point of hospital discharge has been made
Introduce a Housing with Care Strategy that, over time, will increase access to special housing and improve the current housing stock.	The Council's Executive agreed a Housing with Care Strategy in June 2023 which has launched an exciting programme to review and develop the housing with care market locally. Bromley has many not-for profit organisations already working in the housing with care space who are keen to partner with the council to further expand the offer and meet the needs of the growing older adult population. This includes

	expanding supported living and extra care housing including some specialist-built provision for people living with Dementia in line with overwhelming international evidence of the positive impact this type of provision can have on aging well and reducing the severity of frailty. More provision in this space and work with local communities to understand the positive impact on this type of setting, should prevent further increase in demand on more restrictive, residential care provision in the context of an aging population. This aligns with the work the DFG to support people to remain independently in their own home
Further develop digital services with a focus on the customer experience	The Transforming Bromley strategy document is being refreshed as the primary conduit to develop and deliver savings, efficiency, and transformation change programmes. It is being reframed to ensure it remains fit for purpose over the next four years, 2024-28. The Adult Social Care Strategy sets out what the Council plans to do over the next five years to response to demand and cost pressures in the borough, whilst providing good quality and safe care and support to residents, service users and carers. We know that transformational change is required to help us achieve our objectives, therefore the Service has developed a new Adult Social Care Digital Strategy and associated Digital Transformation Programme (DTP) in partnership with the Social Care Institute of Excellence (SCIE). The Adult Social Care Digital Strategy 2024 to 2034 and Plan considers the improvements in digital capabilities, connectivity, and infrastructure, in relation to the care solutions we offer and deliver for our residents – providing more engagement choice, but also supports efficient ways of working.

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

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Summary: Ongoing development of the hospital discharge arrangements have continued to respond to residents changing needs. A recent 13 week 'sprint' named the SPA Half Marathon moved the focus from a transactional approach to discharge to one which transitions residents from hospital to home to continue their recovery and journey back to independence.

Following significant investment through the hospital discharge monies, the system has successfully managed the expected increase in demand through an increased Reablement offer which continues to achieve independence for most clients. This successful strategic investment has effectively managed the increase in population demand mitigating any growth on statutory services.

Further work on developing commissioned pathways for those with the most complex needs will commence in the second half of this year with the commissioning of dedicated D2A beds, alongside a focus on responding to the internal audit recommendations. The hospital discharge model is also being considered through the neighborhood lens where there is perceived value in delivering hospital discharge within neighborhood-based teams to ensure a safe and sustainable discharge from Hospital

Ongoing investment in the multiagency Single Point of Access	The multiagency approach to the SPA has been embedded and now has daily (Mon-Fri) representation from Adult social care with a social worker, reablement with a senior support worker, domiciliary care brokerage and care home brokerage, Bromley Well Age UK navigator, ICB complex case lead nurses, patient advocates (non-statutory), community nurses and community therapists. This offer enables a multidisciplinary triage of all discharge plans ensuring the correct support at the point of discharge and throughout the recovery journey.
Maintaining the discharge to assess model locally	Bromley continues to offer a full discharge to assess model for hospital discharge in line with national best practice. Work on improving the pace of assessment post discharge is underway complimented by the ongoing increase in the number of people being supported through a Reablement offer, reducing the numbers of clients requiring Discharge to Assess. The Home First Huddle (HFH) is now in its second year delivering a robust multi-agency triage for all pathway 3 (discharge to placement) referrals maintaining a strong threshold for discharge to placement from hospital.
A robust early intervention and prevention offer for the projected increase in people living with early frailty	Further investment being made in services supported people living with Frailty including the proposed incorporation of the Frailty Navigator Service into the Prevention and Early Intervention service (Bromley Well)

Complimented by a robust Reablement offer that uses assisted technology and provides support to a wider range of clients to regain independence	Significant investment in Reablement has increased capacity in the service by a third%. The investment has allowed a greater range of referrals to be accepted, including some clients requiring 4 calls per day at the point of discharge. This is much more equitable for Bromley residents allowing more people to have an enablement focused package of care on discharge. Activity in Q3 2034/24 compared to Q3 2022/23 has increased by 48% because of this investment. An Assisted technology offer is being piloted in reablement with a focus around medication management and routine support. Until recently patients who were unable to manage their own medications were not accepted into reablement. The team has used the investment and worked hard to develop this offer and again widen the inclusion criteria giving more Bromley residents the opportunity at a Reablement approach. The use of assistive technology is a corner stone of enhanced care, which is key to delivering our pledge to support as many people as possible to be discharged 'home first'. Further work is planned to ensure the timeliness of this offer.
Mainstreaming the Home First offer piloted throughout Winter 22/23	A review of the Home first offer has created a more defined pathway for people to be supported home with enhanced care, with a greater focus on those with a resolving delirium. The new integrated pathway includes a dedicated MDT including a dedicated social worker, complex case lead nurse and access into advocacy, therapies, nursing and integrated care networks, post discharge offer.
Develop integrated discharge pathways for those with the most complex health and care needs	The new Complex case lead role has been established and is providing the lead professional role for the most complex discharges on all pathways. The interface between the SPA and the proactive care pathway has also been established with patients identified as benefiting for more proactive input to prevent readmission being referred into the pathway. Access into this resource can come pre-discharge, at the point of discharge or post discharge. As a result, the safety net this resource offers is wide and prevents failed discharges as well as avoids admissions.

Implement any learning from the audit of the local Discharge to Assess assessment processes	The internal audit report was received in September with work, jointly led by commissioning and operations, underway to respond to the recommendations.
Health Inequalities	Public Health continue to develop initiatives to enhance collaboration between PCNs and Bromley Healthcare, promoting wellbeing through the development of wellbeing hubs, develop community asset mapping and the rolling out of case management managed via Integrated Care Network multi-disciplinary teams
	Health Inequality Projects : The population health analysis included a pilot of Emis X Analytics 'cloud' tool to merge datasets between providers, which was implemented mid-2023. A data scientist employed by BHC has been interrogating the shared data to establish which segments of the population are currently missing key aspects of care for long-term conditions/frailty.
	The Homeless Health clinical team, made up of a Nurse Practitioner and Care Co-ordinator, continue to work full time out of their base at Bromley Homeless Shelter, in collaboration with the Shelter staff to see homeless clients. Referral pathways have been established and are working well between the Homeless Clinic, the RAMHP team, UTC and A&E. The Clinic will be hosting a Mental Health nurse from Oxleas starting in the New Year and hope to have a Podiatrist from March 2024. There is also ongoing discussion exploring the potential for developing the Bromley Dentistry offer for homeless patients. Project data shows the team have seen 83 individual clients, 104 self-referrals, and a total of 276 appointments, in partnership with Bromley Homeless Shelter the project was also awarded Homeless Project of the Year by Affordable Housing.
	Pro-active Care Case Management Pilot Data sharing agreed and we are running searches within GP emis. This identified 65 patients initially, the care coordinators are consenting and referring to the ICN.