WORKING TOGETHER TO IMPROVE HEALTH AND CARE IN BROMLEY

COVID-19: SEL System Recovery Plan

September 2020

Contents

One Bromley Recovery - Plan on a page

Context & Introduction

Our Vision

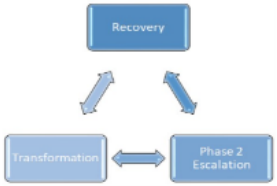
One Bromley LCP is comprised of the signatories to the Bromley Alliance, which was signed in October 2017. One Bromley is a partnership of commissioners, all local NHS providers and the Third Sector Enterprise which aims to work together as a single system to:

- Enhance and improve the range, quality and effectiveness of services available to local people
- Enable partners and services in Bromley to work as a single system to deliver integrated care

One Bromley will strengthen this approach by continuing to bring together providers, voluntary services and commissioners to build on the existing good work and deliver even more personalised and integrated care. This plan is to build on successes such as the Integrated Care Networks and replicated this across many other programmes of care. Patients need support from health and care professionals that act as one team and work for organisations that behave as one system.

How will we achieve our vision

- One Bromley System Approach to Recovery Planning
- Joint ownership from all stakeholder organisations in the Local Care Partnership
- Reflect the Borough local needs and population
- Strong Focus on inequalities and supporting vulnerable communities
- Aligns with the wider South East London and London approach
- Learns the lessons from the pandemic response to develop into future improvement plans
- Develop an agreed action plan for the next 18 months with clear milestones and ownership



Population Health

One Bromley's approach to Population Health

The Population Health strategy for One Bromley continues to develop infrastructure, intelligence and intervention considering our priorities, resource, systems and processes. Key to the success of this programme will be collaboration and It's main priority will be prevention.

Health & Wellbeing Priorities

10 population health priorities have been identified selected based on evidence from the JSNA and PHOF as to what health issues could be the biggest risks to Bromley residents. These priorities are managed using 'The Life Course' approach.

Inequalities

As part of our response planning, we have considered the recent Public Health England review of disparities in risks and outcomes for Covid-19. The PHE analysis has looked into effects of age, sex, deprivation, region and ethnicity. A key priority for our partnership is addressing the broader socio-economic determinants of health and wellbeing, including inequalities exacerbated by the effects of the Covid-19 outbreak.

Wave 2 Preparation & Response

Our recovery and response will be important in the planning for a potential second wave of the Covid pandemic. We will work collaboratively to gather more intelligence on local inequalities , develop a robust and flexible demand & capacity model, continue to build and deliver on our 'planning for recovery' priorities, and strengthen and embed our '10 key messages.'

Planning for Recovery

The following priority areas all have robust actions plans in place for delivery.

Urgent Care - Reporting to the A&E Delivery Board. Winter Planning and contingencies for future spikes in Covid. Continuation and development of the Single Point of Access.

Frailty - Working through the Frailty Task & Finish Group. Optimising the proactive care pathway. Developing the frailty service across the hospital and community. Supporting patient identification.

Mental Health - Through the Mental Health Strategic Partnership Board. Taking forward the Bromley Mental Health and Well Being Strategy. Develop primary care offer. Providing early intervention community support. Develop an integrated recovery and rehabilitation pathway.

Elective Care - Working with the PRUH across the system as part of South East London in prioritising next areas of transformation. Supporting clear communications to patients on services available.

Children & Young People - Digital first approach & virtual clinical appointments. Setting up of a Hospital @ Home model. Community Services, vulnerable C&YP, including safeguarding. Screening & prevention.

Long Term Conditions - Virtual access for diabetes education and pre diabetic education. Support community providers to deliver diabetes interventions and work with APCP. Identify PCN diabetes leads. PodWard Clinic to be implemented at the PRUH.

Care Homes - Led through the Care Homes Board. Taking forward the actions set out from lessons learned through the Covid pandemic. Wide ranging programme of work across Health and Social Care.

Medicines Management - Working with South East London Medicines Management Teams in developing priorities to be implemented locally.

End Of Life Care - Re-establishment of the End of Life Steering Group. Working with partners including St Christopher's to ensure services build on the integration with other services across Bromley. Taking forward previous plans to increase Co-ordinate my Care utilisation in Bromley.

Working Together - The Case Studies

Case Study 1 – Single Point of Access (SPA)

A SPA was established in April 2020 bringing together ONE Bromley partners to provide a single point of access to all community discharge pathways, in line with national legislation.

Lessons Learned

C2C refer to all community services has streamlined discharge pathways
MDT approach allowing fluid movement between pathways
Agreeing discharge at point of referral for some pathways – improving quality and timeliness
Welfare Calls provide significant system benefits including improving quality of discharge and maximising independence

Case Study 2 – Bromley Community Covid Management Service (BCCMS)

BCCMS provides a monitoring and treatment service for any patients and is run by a combination of GPs and Community Matrons working with Bromley Healthcare and Bromley GP Alliance.

Lessons Learned

Strong partnership working to effectively deliver an integrated BCCMS model within a tight timeframe
Smooth transition through the pathway with an effective multi-disciplinary clinical input at the CMS hub to manage presenting need
Good feedback from primary care on service model and delivery

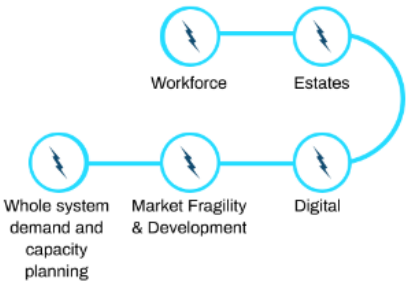
Case Study 3 – Care Homes

The infrastructure around Care homes during the pandemic has been undertaken in a much more integrated and streamlines way across the LA and CCG which has led to excellent leadership and support being provided to the sector.

Lessons Learned

PPE and infection control training opportunity to expand on virtual training
Support to providers via a dedicated line
Foundations of MDT for care home support
CMC – worked well, continue to roll out
EOL work in care homes has improved

One Bromley System Enablers



10 Key Messages

10

- Collaboration
- Inequalities
- Intelligence
- Communications & Engagement
- health & Well being
- New ways of working
- Leadership
- Organisational Change
- Innovation
- Voluntary Sector

ONE BROMLEY

1. Context & Introduction

Our Vision

The One Bromley Local Care Partnership (LCP) is a partnership of NHS and Local Authority commissioners, all NHS health providers and the Bromley Third Sector Enterprise to formally work together to deliver seamless and personalised integrated care for Bromley residents. One Bromley works together as a single system to:

- Enhance and improve the range, quality and effectiveness of health and care services.
- Enable partners and services in Bromley to work as a single system to deliver integrated care.
- Support and empower residents to take better care of their own health
- Reduce duplication and enable more people to be cared for in the community.

One Bromley work as an integrated system to build on the existing good work and deliver even more personalised and joined up care. It will build on successes such as the Integrated Care Networks and replicate this across many other programmes of care. Patients need support from health and care professionals that act as one team and work for organisations that behave as one system.

System progress – Where we are now

The One Bromley work programme and identification of priority areas was developed in conjunction with stakeholders. Phase 1 focused on initiatives that support Urgent & Emergency Care and the management of winter pressures including proactive care, frailty, care homes and end of life.

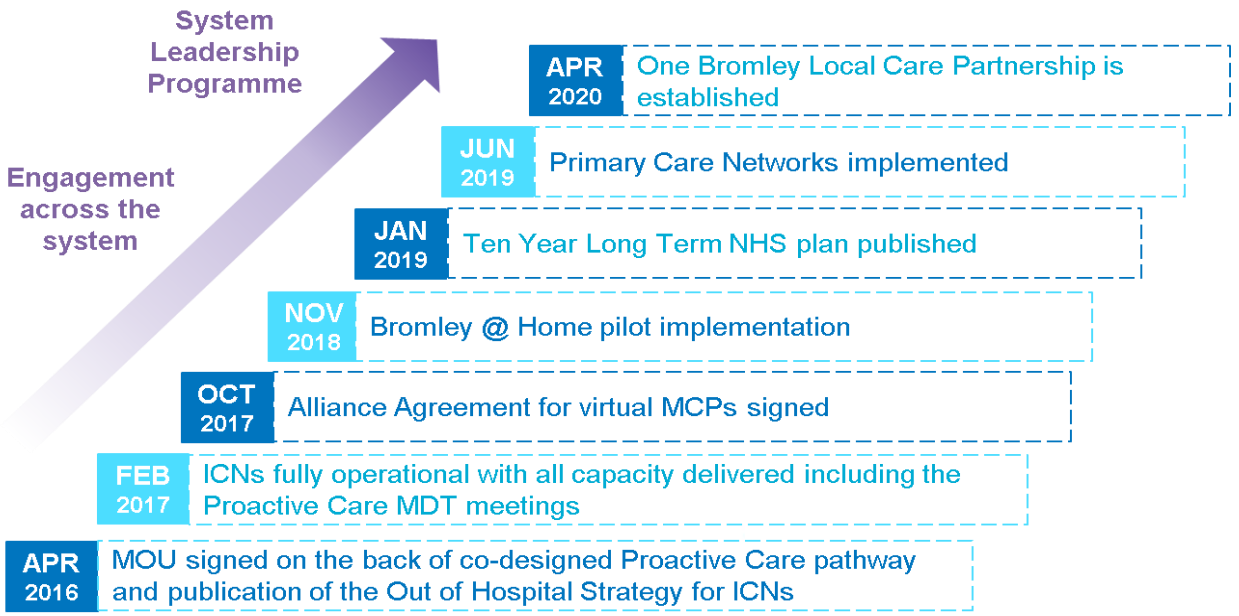
Work is being taken forward on continued development of the Local Care Partnership model in Bromley, which will be aligned to the South East London Integrated Care System and Bromley placed based commissioning, meeting the requirements set by NHS England / Improvement

Key schemes

- Urgent & Emergency Care
- Frailty & Proactive care pathway
- End of Life care
- Care Homes
- Elective care
- Mental Health
- Children & Young People (C&YP)
- Long Term Conditions incl. Diabetes
- Medicines Management
- Primary Care

Enablers

- Whole System Demand & Capacity Planning
- Digital
- Estates
- Market Fragility
- Workforce
- Communications & Engagement

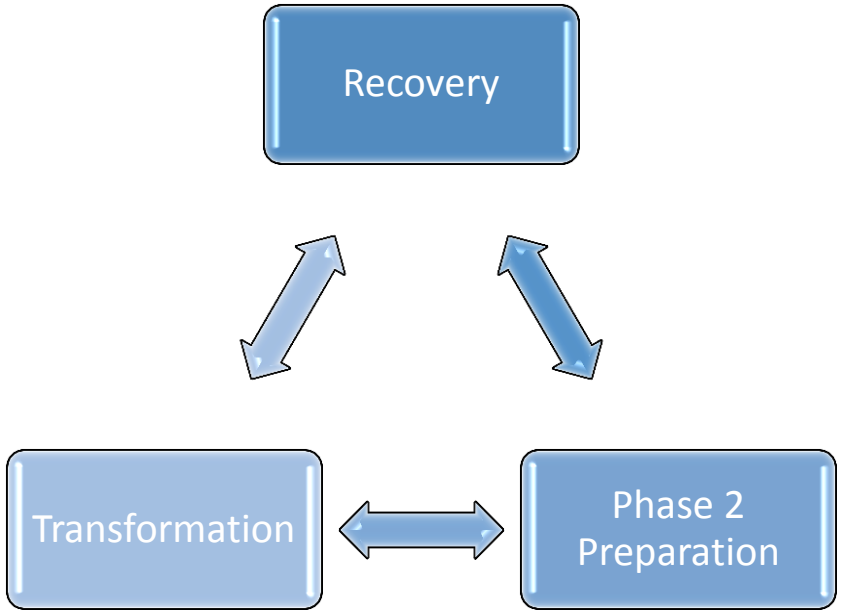


ONE BROMLEY

Bromley System Approach to Recovery Planning

The One Bromley System Recovery Plan forms one part of the wider Borough-wide Strategic Recovery Plan for Bromley to meet the needs of local residents and patients

- Joint ownership from all stakeholder organisations in the Local Care Partnership
- Reflect the Borough local needs and population
- Strong Focus on inequalities and supporting vulnerable communities
- Aligns with the wider South East London and London approach
- Learns the lessons from the pandemic response to develop into future improvement plans
- Develop an agreed action plan for the next 18 months with clear milestones and ownership
- Complements plans for social and economic recovery led by LB Bromley



2.Population health: context

The Bromley picture

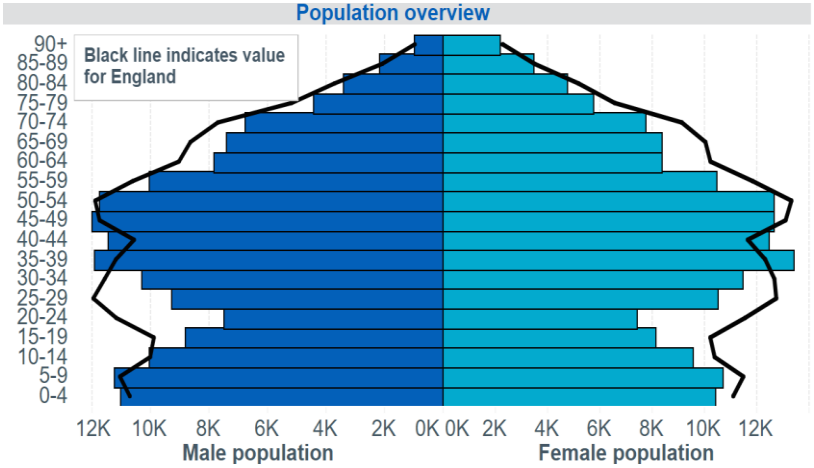
Bromley has one main acute hospital (Princess Royal University Hospital). 80% of patients treated at the hospital are from Bromley and 90% of Bromley residents use the hospital. Bromley Healthcare provides community health services, Oxleas NHS Foundation Trust provides mental health services and St Christopher's provides hospice services. Bromley Third Sector Alliance is the Community Interest Company encompassing the major third sector Bromley providers.

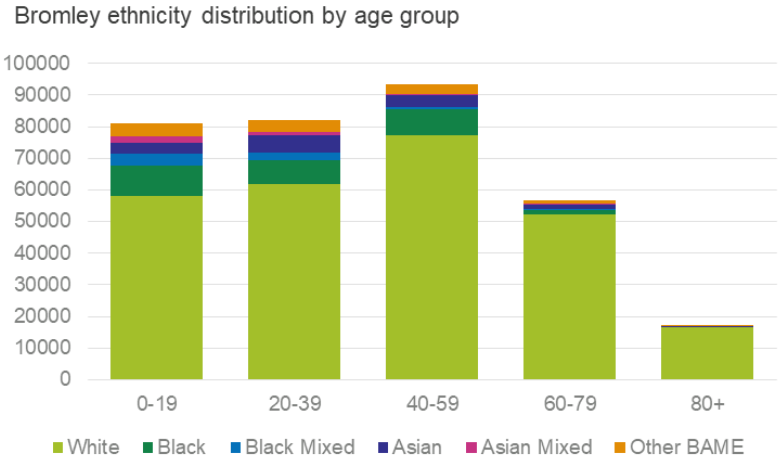
The latest (2017) estimate of the resident population of Bromley is 330,909, having risen by 28,235 since 2001. The resident population is expected to increase to 342,548 by 2022 and 351,841 by 2027.
The number of 0 to 4 year olds is projected to decrease by the year 2022 to 21,300 and then to 20,750 by 2027. The proportion of older people in Bromley (aged 65 and over) is expected to increase gradually from 17% of the population in 2017 to 18 % by 2022 and 19% by 2027. As the numbers of older people in Bromley are rising, health and social care provision needs to reflect the increased need.

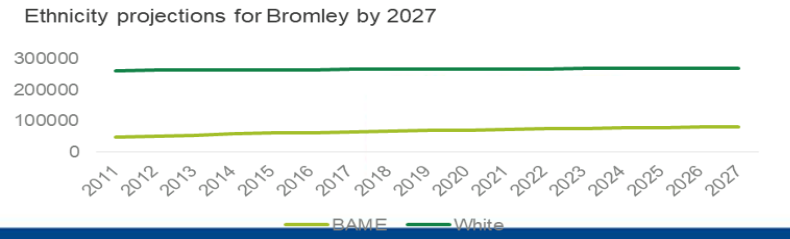
The pattern of population change in the different age groups is variable between wards. Some wards, such as Darwin, have a large rise in the proportion of young people and others such as Biggin Hill a large rise in over 75s.

The latest (2017) GLA population projection estimates show that 19% of the population is made up of Black, Asian and minority ethnic (BAME) groups. Children and young people make up the highest proportion of the BAME population in Bromley.
The BAME group experiencing the greatest increase within Bromley's population is the Black African community, from 4.7% of the population in 2017 to 6.6% of the population in 2031.

Ethnicity Charts from Kings Health Partners. Population Overview from www.viewpoint.nhs.uk



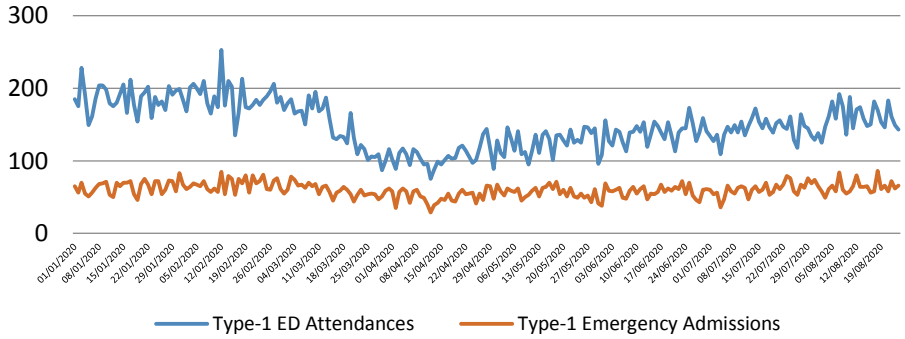




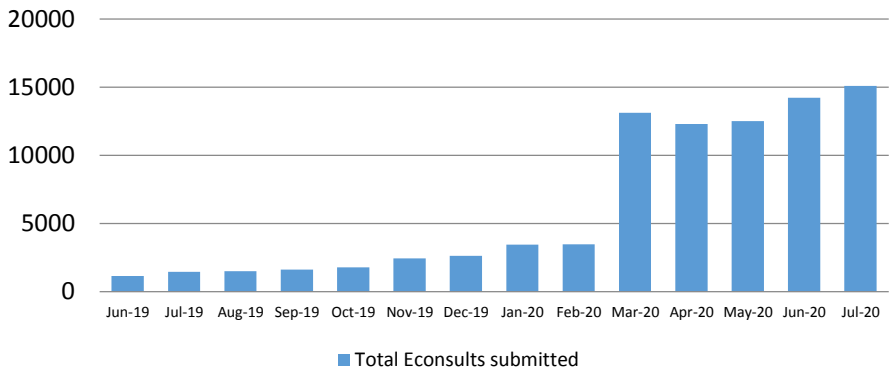
2. Population health: Impact of COVID-10 (1 of 2)

Monitoring the Covid impact One Bromley has developed a robust monitoring pack which looks at the impact of covid 19 across our system. This includes detailed metrics from both acute and community care. As with other areas of the country, recently there has been a small rise in the number of cases as lockdown eases. Currently the number of cases for Bromley is 1,606, with deaths at 345 (see next slide). Bromley's current shielded patient list is 12,282 for those registered with a Bromley GP and 12,063 for those Resident in Bromley. Emergency admissions remained fairly stable at the PRUH throughout the Covid pandemic, however there was a significant drop in Type 1 A&E attendances, which are now slowly increasing again as lockdown measure ease. In Primary Care, as of April 2020 all practices in Bromley are offering Econsult to their patients in response to the national requirement for total triage and Covid-19. As a result of this, utilisation has increased significantly from 3481 consultations submitted in February 2020 to 15,091 in July 2020. There have also been 5598 video consultations delivered across Bromley in the last three months (17TH May – 17th August)

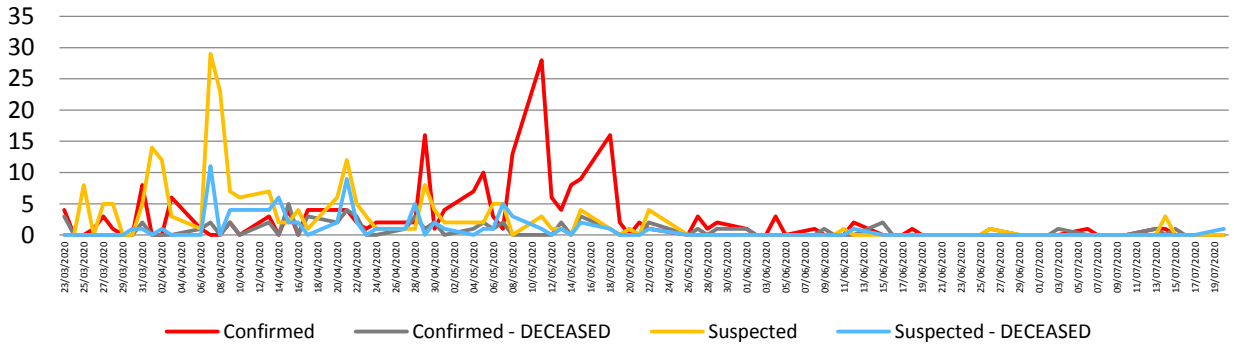
PRUH all patients Emergency Attendances and Admissions Data from SEL analytics team



Total Econsults submitted Data from eConsult Health Ltd 2020



Care Homes - Total Confirmed and Suspected COVID-19 cases (Daily New Cases) data collated by GP Alliance

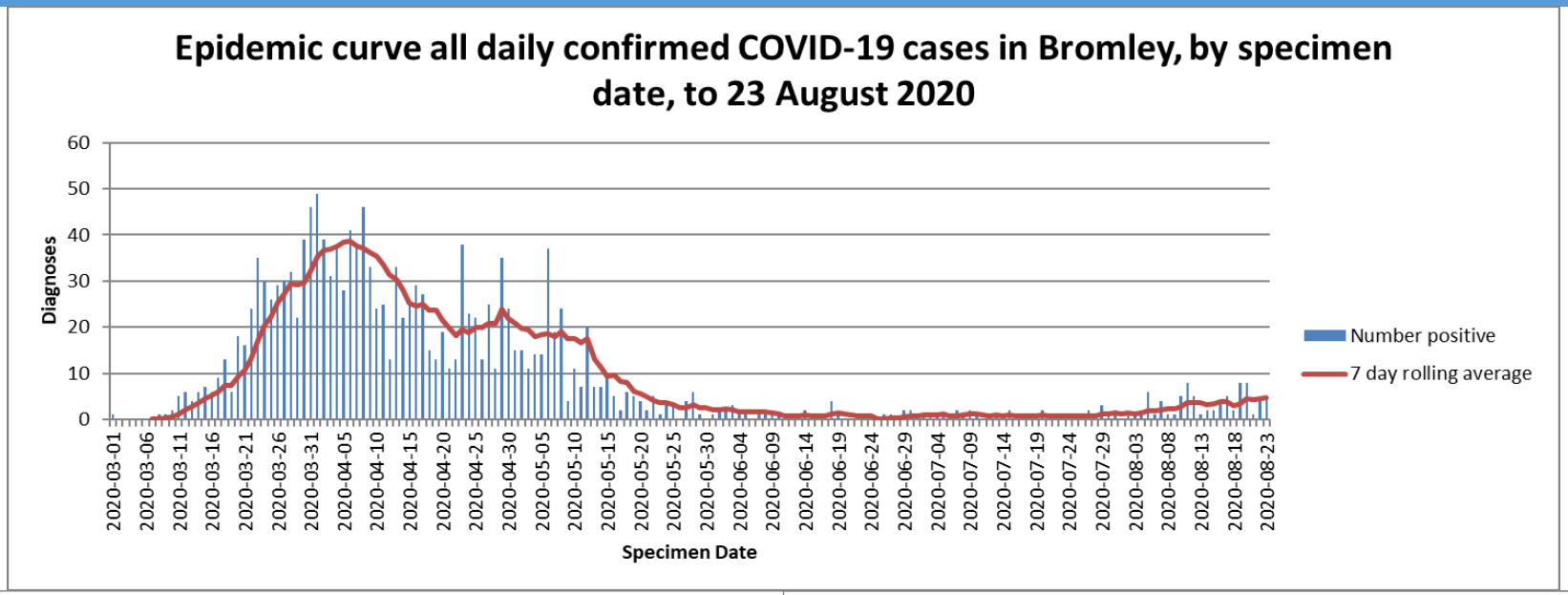


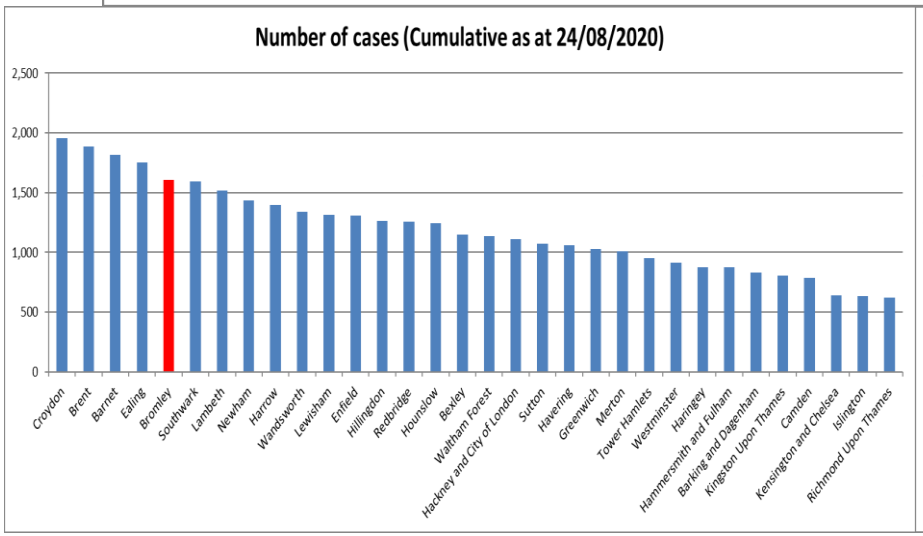
Shielded Patients - Numbers as at 17/06/20 Please note numbers a likely to change as the patients continue to be added and removed from the lists

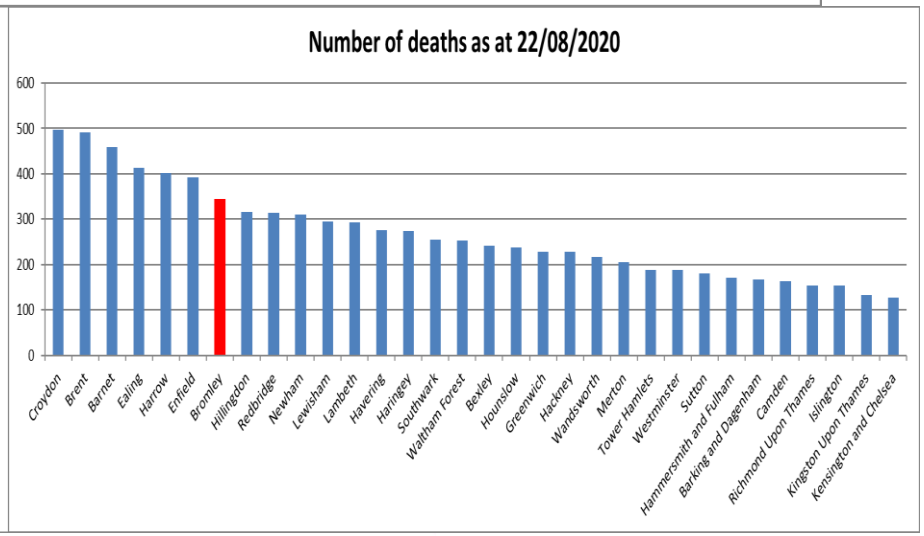
	Shielded Patients
Registered with a Bromley GP	12,282
Resident in Bromley borough	12,063
Resident in Borough & Registered with a Bromley GP	11,488

ONE BROMLEY

2. Population health: Impact of COVID-10 (2 of 2)







Data sources: Epidemic curve - PHE Positive COVID-19 cases. Number of cases - https://coronavirus.data.gov.uk/ Number of deaths https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/datasets/deathregistrationsandoccurrencesbylocalauthorityandhealthboard

ONE BROMLEY

2. Population health: areas of focus (1 of 4)

One Bromley's approach to Population Health

The Population Health strategy for One Bromley continues to develop system infrastructure, gather intelligence and implement interventions to support the delivery of the One Bromley programme of work. Key to the success of this programme will be collaboration and It's main priority will be prevention. Whilst that strategy is developed, we are focusing on the proactive care pathway, which aims to keep vulnerable patients out of hospital. The aim is to determine outcomes and benefits and undertake population segmentation to better identify the most appropriate patients for this pathway.

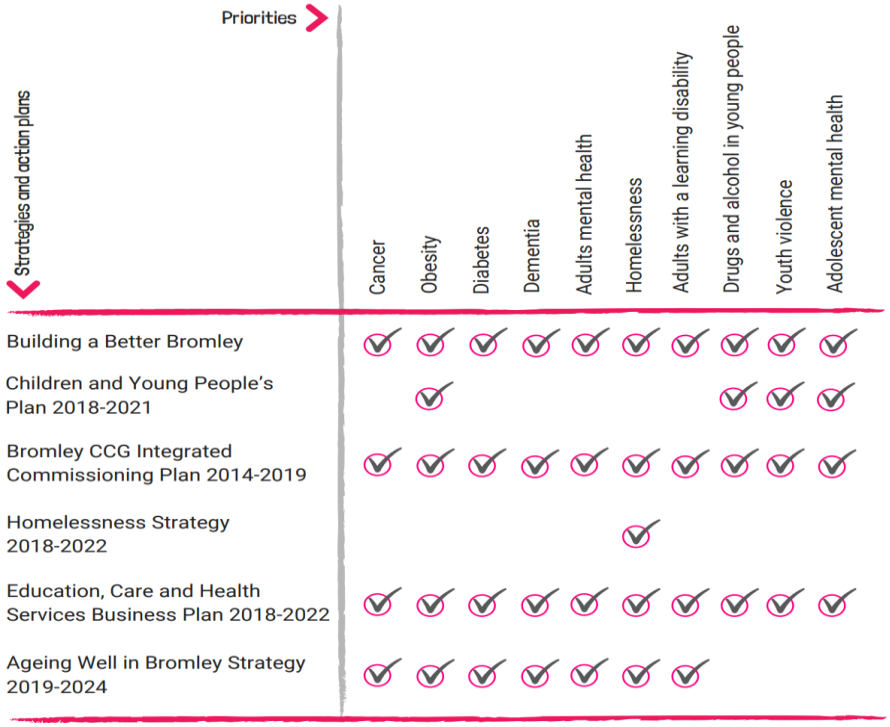
Health & Wellbeing Priorities

Ten population health priorities have been identified selected based on evidence from the Joint Strategic Needs Assessment (JSNA) and Public Health Outcomes Framework (PHOF) as to what health issues could be the biggest risks to Bromley residents. These priorities are managed using 'The Life Course' approach.

The life course approach seeks to prevent and control diseases by identifying critical stages in life from preconception through pregnancy, infancy, childhood, adolescence, adulthood and old age, where interventions will be most effective. A life course approach investigates the long-term effects of physical and social exposures experienced during these aforementioned
critical life stages on health and disease risk.

It also examines the pathways (biological, behavioural and psychosocial) influencing the development of chronic diseases and operating across an individual's life course or across generations. The life course approach to health offers a strategic model that can be used to best plan public health interventions that relate to the priorities agreed within the Joint Health and Wellbeing Strategy (JHWS). Interventions planned using a life course approach will be timely, effective and provide lasting benefits.

Health & Wellbeing Priorities and strategies matrix



2. Population health: areas of focus (2 of 4)

One Bromley's approach to Population Health

The below table demonstrates the impact the Coronavirus pandemic has had on the Bromley Health & Wellbeing priorities and some of the actions that are in place to address this impact.

Priority Area	Covid Impact update
Cancer	The group has been suspended during Covid pandemic. Potential impact of pausing cancer screening and other preventative measures and services on population outcomes. screening programmes are starting e.g. cervical screening, but this is led nationally by PHE /NHSE
Obesity	The group has been suspended during Covid pandemic. However, work and oversight on Tier3 services continues but is delivered on-line. Potential impact on effectiveness of the service which could be particularly important as evidence suggests worse outcome of Covid infection with obesity. Strategic group meets regularly and is considering full recovery depending on the NHS advice about different services
Diabetes	The group has reconvened in June and will continue to meet regularly. Potential impact on patients due to pausing of non-essential services. Diabetes is shown to be a risk factor for worse outcome of Covid infection. Services mostly returning to normal.
Dementia	Mental Health Strategic Board suspended. While the Dementia Respite at Home Service (Bromley Lewisham and Greenwich Mind) remains open, face-to-face delivery was suspended from Wednesday 18th March to comply with the Public Health measurers put in place as a result of COVID. One to one telephone support to service users is provided by staff working remotely at home. Practical support (such as delivering food or medication) has been provided to service users most vulnerable by the service. In consultation with commissioners, BLG Mind is progressing with plans to resume face-to-face operations from August 2020. An action plan outlining the high level actions needed to achieve this has been agreed and is being implemented. The Dementia Post Diagnosis Support Service (Dementia Hub) has also suspended all face-to-face delivery. One to one telephone support to service users is also provided by staff working remotely at home. However, the nature of the support has been adapted during COVID to meet the needs of the users. For example calls times are longer as service users and carers require additional emotional support. Many of the services Dementia Advisors' would have signposted people to are not currently operating as usual. Many people who use the service have reported feeling anxious and isolated, those most vulnerable have been given additional support. New referrals are triaged over the telephone and new online support groups have been set up via Zoom and private Facebook groups. At the end of April 2020, BLG Mind was awarded a new 5 year contract to deliver the Dementia Hub from 1st July 2020. Mobilisation of the new service is being implemented alongside the delivery of the current service. In consultation with commissioners, BLG Mind has continued to deliver all aspects of the service with slight modifications to the delivery method where necessary.

2. Population health: areas of focus (3 of 4)

Priority Area	Covid Impact update
Drugs and Alcohol	The case review process has been deferred due to COVID-19. The drug and alcohol service is essential and has therefore continued during this time; although how it delivers support has had to shift from mainly face to face to telephone/on-line. Service development plans have not been impacted. Many of the service users are shielding or self-isolating as they have complex health conditions. They are a high risk group for worse outcomes of Covid infection. While Bromley Adult Drug and Alcohol Service (Change Grow Live) remain open for new referrals and walk-ins, provision is consolidated to one site operating with a skeleton staff team. One to one telephone support to service users is provided by staff working remotely at home. To protect service users and reduce the risk of spreading Covid-19, there has been changes to the daily collection of opiate substitute medications from pharmacies based on individual's risk assessment. Naloxone (opioid overdose reversal drug) is offered to every opiate user, if accepted, medication safe storage boxes would then be delivered to every family they support. There is also an Emergency telephone line for service users and professionals available between 7am-11pm seven days per week. The Young People's Service Team (Bromley Change) has ceased all satellite work and face to face contacts but is working remotely from home supporting young people via telephone/SKYPE with new referrals being triaged over the telephone. The service continues to join child protection conferences and other social care meetings as required via telephone/SKYPE In consultation with commissioners, CGL's national organisation plans to gradually increase face-to-face contact in services over the summer with guidance and resource published last week to help staff work safely and effectively in the coming months.
Youth Violence	Recent MOPAC briefings circulated to London Heads of Community Safety stated that anecdotal information from hospitals indicates presentations of young people who are victims of youth violence are increasing again after an initial reduction in presentations at the beginning of the COVID-19 pandemic. In terms of knife crime, since lockdown figures from MOPAC indicate across London an initial drop to April. An increase in May but figures are still below what would normally be expected compared to last year. MOPAC figures indicate a 25% reduction of Victims of knife crime with injury between March and April. Those young people identified at the highest risk of CSE, Exploitation and gang affiliation in Bromley have continued to be risk managed during lockdown through regular MEGA meetings. YOS risk panels have continued to take place and YOS workers have continued to manage individuals via acceptable social distancing communication methods. The borough Violence Reduction Action plan has been maintained throughout the lockdown period, capturing the various partnership activities undertaken to reduce and prevent serious violence, including youth crime. The lead for policy & commissioning in the London Violence Reduction Unit has very recently visited Bromley to assess progress against the violence reduction action plan. The visit went well and official feedback is due shortly. The 2020 Action Plan is now going to be refreshed The planned County Lines theatre workshop for schools, arranged by Public Health, had to be postponed due to the school closures. MOPAC funding to enable the production to take place in Bromley schools early next year, has been secured.
Homelessness	As per Central Government guidelines work has been completed to get all rough sleepers into accommodation and off the streets. Work is not commencing on setting up a system for medical health assessments for all homeless going forward A multi-agency panel for rough sleepers to protect them from Covid-19 was set up. A group of very high risk and vulnerable rough sleepers were identified with rapid assessment carried out involving London Street Rescue Outreach team, mental health, drugs and alcohol teams. Arrangements were then put in place to shield these individuals from Covid-19. Considerations were also given to those sofa surfing individuals who may be at risk of becoming homeless. They were identified and given help and support as appropriate. In addition, a list of homeless people who require medical and health assessment has been identified. A multi-agency task and finish group has been set up to consider how these individuals can be assessed with the aim to agree how ongoing assessment can be set up and offered to the homeless people post Covid. Consideration is being given to establish the panel for rough sleepers on a permanent basis to support the longer term management of homelessness.

2. Population health: areas of focus (4 of 4)

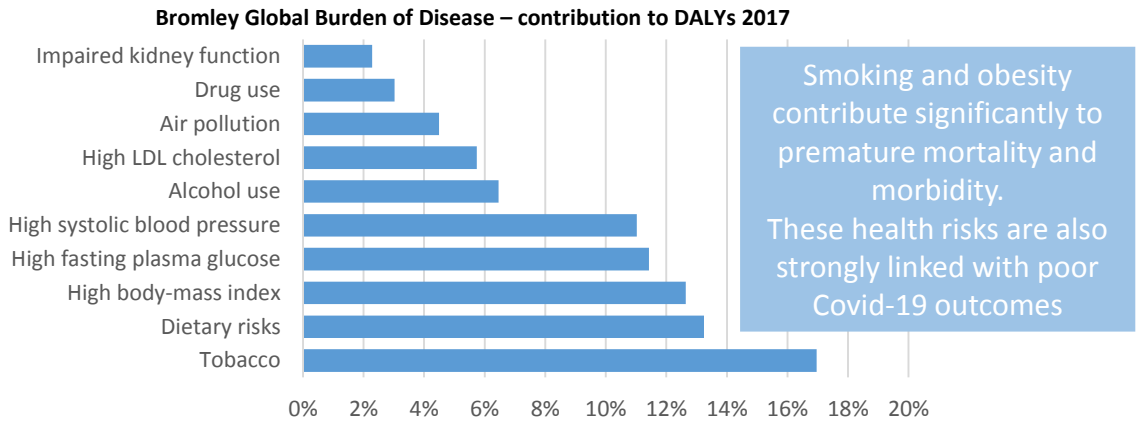
Priority Area	Covid Impact update
Learning Disability	The LD Strategy was put on hold for a few months during the crisis but is now being picked up on and work is being progressed towards implementation with the LD Strategic Board. Covid related impacts on the local LD community: Day services have been suspended with as yet no agreed date yet to reopen Whilst emergency respite was available., short term building based respite has been suspended There has been added pressures for family carers as people with LD have struggled with lockdown and this, combined with the closures of day/respite has increased pressure. Regular contact has been maintained by the social work team People with Direct Payments have the services on which they spent them temporarily closed but additional flexibility of their use has been agreed There is work underway to refresh the LD/ASD programme being led by SEL CCG, with a renewed focus on reducing inappropriate inpatient admissions and ensuring that community and prevention services are in place to deliver improvements. There has been disruption to the delivery of annual health checks for people with LD from GP Practices and this is being considered by the primary care commissioning team.
Adults Mental Health	The Suicide Prevention Steering Group has been suspended. Partners have been contributing to the SEL CCG mental health campaign - Free your Mind - aimed at providing people with information to support their mental health. Mental Health Strategic Board has been suspended. Drop in referrals across the board – now 50/60% of normal. Focus on children with disabilities and direct payments and increased in vulnerability as some of our children are transitioning Closed 2 wards. Shifted from inpatient to community with some support going in to them. A different level of clinical risk was applied. People divided into a RAG system – some people seen online (A&G), face-to-face for those at risk (R). Medication clinics carried on. Some pathways disrupted e.g.; dementia pathway have now built up a longer waiting list and ASD which can cause other mental health problems whilst waiting for the diagnosis and help/support. Bromley Council/CCG are working together to develop an action plan for mental health, in order to deliver against the local MH and Wellbeing Strategy priorities. New working arrangements between SEL and local boroughs are being put in place for the management of the Oxleas contract.
Adolescent Mental Health (emotional health and wellbeing)	Drop in referrals across the board – now 50/60% of normal. Bromley Academies all remained open to key workers and children with social workers and those vulnerable children CAMHS and BromleyY shifted to online services – limited face-to-face. Initial feedback is it is working well and would like to continue this after covid. Safeguarding concerns exist. Face-to-face will carry on where it works. EHCPs disrupted as health input was reduced due to the Covid 19 impact and redeployment of staff. Concern about presentations in A&E having fallen. Referrals have dropped significantly. Concern as services re-open how much presentations will we see being more complex and acute. Increased number of referrals (post June) in which covid-19 or the implications of the lockdown are mentioned. A significant impact on the ability to deliver the Bromley trailblazer projects (four week waits/mental health support in schools) with a planned NHSE evaluation of the projects also delayed, but no clarity of post-April 2021 funding. We have engaged support to take this forward. There are concerns from providers that schools will have unrealistic expectations from services .

2. Population health: Tackling Inequalities - Addressing the impact of Covid-19 (1 of 3)

As part of our response planning, we have considered the recent Public Health England review of disparities in risks and outcomes for Covid-19. The PHE analysis has looked into effects of age, sex, deprivation, region and ethnicity, but it does not take into account the existence of comorbidities, which are strongly associated with the risk of death from Covid-19 and are likely to explain some of the differences. Continuing to improve the holistic management of long-term conditions in Bromley is a key priority for our partnership, as (working with VCSE colleagues) is addressing the broader socio-economic determinants of health and wellbeing, including inequalities exacerbated by the effects of the Covid-19 outbreak.

However, as an area with a diverse population and a diverse workforce, we recognise our shared responsibility to address emerging disparities in risks and outcomes specifically in our immediate and future plans. Our recovery and response will be important in the planning for a potential second wave of the Covid pandemic. The Bromley Public Health team, One Bromley delivery team and others will work closely to gather more intelligence on the effect of local inequalities to aid our preparations. This will work along side the Bromley demand and capacity modelling work, discussed later in this pack, and support robust planning for our wave 2 preparations.

Bromley Health Risk Factors

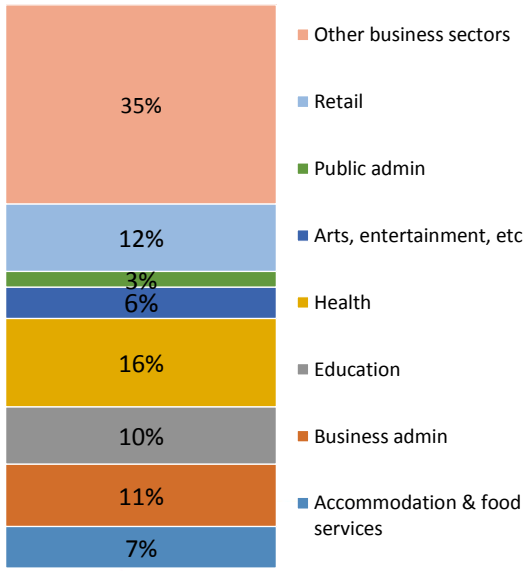


Smoking and obesity contribute significantly to premature mortality and morbidity.
These health risks are also strongly linked with poor Covid-19 outcomes

Indicator Name	Age	Time period	Value
Estimated smoking prevalence (QOF)	15+ yrs	2018/19	14.1%
Hypertension: QOF prevalence (all ages)	All ages	2018/19	13.3%
Diabetes: QOF prevalence (17+)	17+ yrs	2018/19	5.7%
Estimated prevalence of diabetes (undiagnosed and diagnosed)	16+ yrs	2017	8.3%
Percentage of people with type 1 diabetes who are of minority ethnic origin	All ages	2018/19	11.1%
Percentage of people with type 2 diabetes who are of minority ethnic origin	All ages	2018/19	20.8%

Data sources Kings Health Partners

Bromley Occupations



2. Population health: Tackling Inequalities - Addressing the impact of Covid-19 (2 of 3)

Bromley Index of Multiple Deprivation (IMD)

There are 7 domains of deprivation, which combine to create the Index of Multiple Deprivation (IMD2019):

Income (22.5%)
Measures the proportion of the population experiencing deprivation relating to low income

Supplementary Indices

Income Deprivation Affecting Children Index (IDACI) measures the proportion of all children aged 0 to 15 living in income deprived families

Income Deprivation Affecting Older People Index (IDAOPI) measures the proportion of those aged 60+ who experience income deprivation

Employment (22.5%)
Measures the proportion of the working age population in an area involuntarily excluded from the labour market

Education (13.5%)
Measures the lack of attainment and skills in the local population

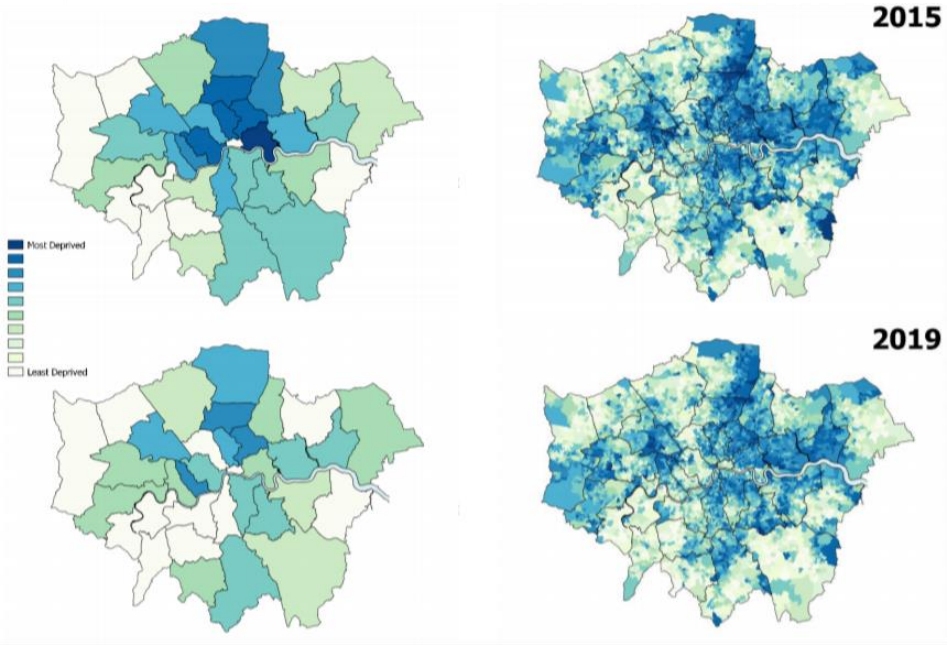
Health (13.5%)
Measures the risk of premature death and the impairment of quality of life through poor physical or mental health

Crime (9.3%)
Measures the risk of personal and material victimisation at local level

Barriers to Housing & Services (9.3%)
Measures the physical and financial accessibility of housing and local services

Living Environment (9.3%)
Measures the quality of both the 'indoor' and 'outdoor' local environment

Overall there has been an improvement of Bromley's IMD score between 2015 and 2019



Data Source Gov.uk national statistics

Further work in development

Jointly Directors of Public Health across SEL are developing an approach to create borough specific chapters on an SEL wide Joint Strategic Needs Assessment. Meetings are underway to scope and develop that response. Kings Health partners continue to develop their work to populate the impact analysis for all 6 boroughs as part of the phase 1 response, to include a summary of mental health impacts and reference to the need to support rehabilitation of those recovering from COVID-19. Phase 2 of the work will be a more in depth look at the impact of Covid in further granularity and will support the JSNA chapter on Covid over a longer timescale as well as our wider understanding, recovery and planning. The One Bromley Development Team, with Bromley Public health colleagues will also look to develop our pre Covid risk stratification, interventions and monitoring measures.

2. Population health: Tackling Inequalities - Addressing the impact of Covid-19 (3 of 3)

The following table details the risk factors associated with severe Covid response and increased mortality and the potential impact those factors have when applied to Bromley specific residents. We have also included our public health priorities as a response to these risks and impacts.

	Age and Gender	Deprivation	Ethnicity	Occupation	Health Factors/Comorbidities
Risk Factors	• Those 80 or over were seventy times more likely to die than those under 40. • Males had a statistically significantly higher rate of death (9.9 deaths per 100,000) compared to females.	COVID-19 has had a proportionally higher impact in the most deprived areas when compared to all deaths. Some groups are particularly at high risk • Migrants • Those with Nil recourse to public funds • Homeless • Children and Young people (impact of education)	The risk of dying is higher for those in Black, Asian and Minority Ethnic (BAME) groups than in White ethnic groups.	• Caring occupations including social care and nursing auxiliaries and assistants. • Those employed driving private and public vehicles including taxi and minicab drivers and chauffeurs. • Security guards and related occupations; including those in care homes.	• Hypertension • Cardiovascular diseases • Diabetes mellitus • Obesity • Smoking • COPD • Chronic kidney disease
Potential Impact on Bromley Population	• 17,400 people or 5% of the Bromley population are aged 80 or over (ONS) • There are just over 12,000 Bromley residents on the shielding list	• 10% of those 60 and over are income deprived. 13% of those under 16 are from income deprived families (PHE) • Crude rates of mortality in Bromley show an inverse relationship with deprivation than expected, those in the more affluent areas having higher rates of mortality. No apparent association exists between all cases and deprivation (PHE)	• Bromley has a BAME community of nearly 69,000 people (GLA) • Recording of ethnicity needs to be improved to better understand the local epidemiology	• 1000 employed in taxi and passenger land transport • 17,000 in human health and social work activities (NOMIS BRES)	• Hypertension 13.3% • CHD 2.8% • Diabetes (17+) 5.7% • Obesity (18+) 7.9% • Smoking (18+) 11.5% • COPD 1.4% • CKD (18+) 3.4% (PHE GPPP)
Priorities for our Recovery Plan	• Integrated support to our shielded population. • Development of Covid-19 protected and risk-managed pathways co-ordinated through our PCNs • Focus on improving LTC management	• Mitigating social determinants by improved housing, reducing overcrowding, improving nutrition • Targeted investment in prevention to support population health and wellbeing (social prescribing)	• A focus on BAME support co-ordinated across mental and physical health services. • Effective communication and engagement across all of our communities to ensure that equal access to advice, guidance, services and support.	• A rigorous and co-ordinated focus on staff mental and physical heath and wellbeing across NHS, local authority and VCSE organisations. • Ensuring ongoing availability of PPE and testing, and effective “zoning” and management of patients and service users across all care settings	• Reducing smoking prevalence, • Improving proportion with healthy weight and access to good nutrition, • Improved management of LTC • Focus on care home

3. Working together: Key Developments during COVID-19

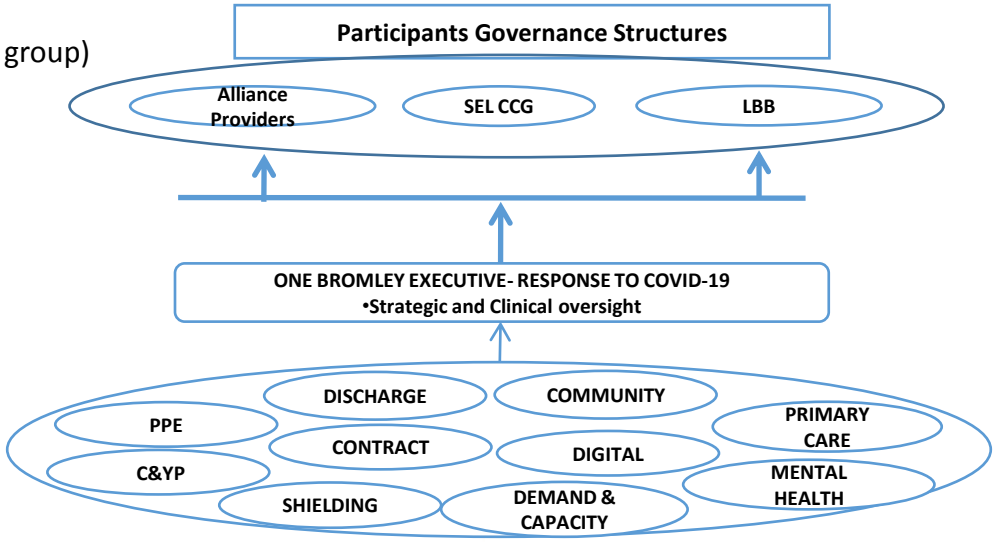
COVID-19: Infrastructure and System actions

South East London (SEL) Control Centre

- A SEL Covid-19 Incident Control Team has been established – to oversee and coordinate SEL's Covid-19 response:
  - Covid-19 response teams in place at each key organisation, noting organisational activity is now primarily focussed on the Covid-19 response and any other business critical activity
  - SEL wide work to support our response in key areas e.g. primary care
  - Local borough oversight and delivery arrangements, including borough resilience groups

One Bromley

- One Bromley Executive has focused on the strategic management of COVID-19 pandemic across the local system. Membership consists of Chief Executives/ Managing Directors and Clinical/ Professional leads across all One Bromley organisations with a remit to:
  - Oversight on and collective delivery of local workstreams which require leadership and co-ordination at a local level
  - Improved communication and response across One Bromley provider organisations. To support and ensure alignment and co-ordination across wider partnership forms including but not limited to:
    - SEL Control Centre
    - Strategic Partnership Group (LBB multi agency group)
    - Local Resilience Forum
    - Local Bromley Operational Delivery Groups
  - Agreed outputs and outcomes
  - Escalation of key risks and issues at ground level



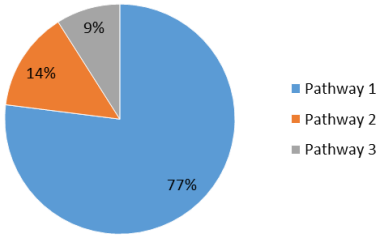
Interim Governance Structure through Covid-19

3. Working together: Case Study 1 – Single Point of Access (SPA)

Description/Background

A SPA was established in April 2020 bringing together One Bromley partners to provide a single point of access to all community discharge pathways, in line with national legislation. The SPA provides acute to community, clinician to clinician hand over with immediate access to community therapies/rehab and nursing provision, as well as domiciliary care or placement, to safely discharge patients. All patients going home are seen within 24 hours of discharge by a therapist to establish the most appropriate community pathway, with assessment of long term care and support needs taking place in the community following a period of recovery.

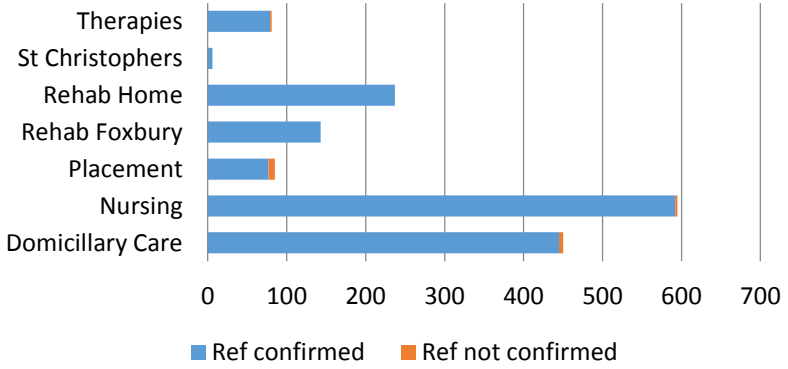
% of patents per pathway



4459 saved bed days in 3 months

75.5% of discharges within 24 hours

257 Welfare Calls in the period



Data as at 220620 from BHC online Qliksense system

Objectives

- Implement an integrated model to provide a single pathway to manage all supported hospital discharges as per the Hospital Discharge Guidance
- Meet requirements in the Adult social Care action plan
- Sustain the Hospital Discharge Service, working across secondary care and community providers in partnership with social care. Includes daily reviews of all patients in a hospital bed on the Hospital Discharge List; prompt and safe discharges when clinically fit and in line with infection control requirements with the planning of ongoing care needs arranged in people's own homes; and making full use of available hospice care.
- Provide wrap around care and support at the point of discharge with patients moved onto the most appropriate pathway following a period of recovery to ensure maximum independence and recovery.
- Gather feedback from patients receiving supported hospital discharge to ensure their views are fed into any improvements or refinements to the service.

Outcomes & Benefits

1	1839 discharges through the SPA to date: 854 from the PRUH, 75.5% within 1 day
2	3047 number of patients managed in the community via the CMS
3	PRUH has remained top 3 performing hospitals in London throughout Covid19 with no delayed transfers of care in the period
4	Improved quality of discharge due to clinician to clinician hand over and agreeing discharge plan and requirements for safe transfer
5	4459 saved bed days from the PRUH in 3 month period
6	Increased access to rehab services (outcome of clinician to clinician hand over and welfare check) increasing level of independence of patients/clients
7	Decreased from 1st to 6th in LAS call outs to care homes in London (April 19 vs April 20). However non-conveyance rate has increased from 24% to 38%

3. Working together: Case Study 1 – Single Point of Access (SPA) - Discussion

Lessons Learnt

- Strong foundations building on the BHC CCC infrastructure to develop the 'SPA'
- Single clinician to clinician phone call to refer to ALL community services has streamlined discharge pathways, reducing confusion and delivering needs led care
- Community MDT approach to meet presenting needs moving away from discreet pathways and allowing fluid movement between pathways
- Agreeing discharge at point of referral for some pathways – improving quality and timeliness
- More effective market management with health and social care POC and placements managed together
- Immediate access to care and support to allow assessment of interim and long term support to happen post discharge
- Achieved parity of esteem between mental and physical health
- Welfare Calls provide significant system benefits including improving quality of discharge and maximising independence
- System enabled by single budget to fund discharge

What does the service look like over the next 6 months / 1 year

The benefits of the SPA have been felt across all organisations in the system and for patients themselves
Within the next 6 months

- Funding of immediate POC and placements will be defined – currently 100% funded by Covid19 Health funding and a key success factor
- Pre-Covid 19 resource will be redeployed into a permanent structure with gaps in the system addressed
- Feedback from patients using supported discharge will be assessed to see if any improvements or refinements need to be made
- Care Managers are co-located within the SPA to better enable discharges into social care

How does the model respond to Escalation in COVID patients/tackle inequalities / other etc..

Management of all hospital discharge including Covid19+ patients. Those that are shielded or vulnerable to Covid19

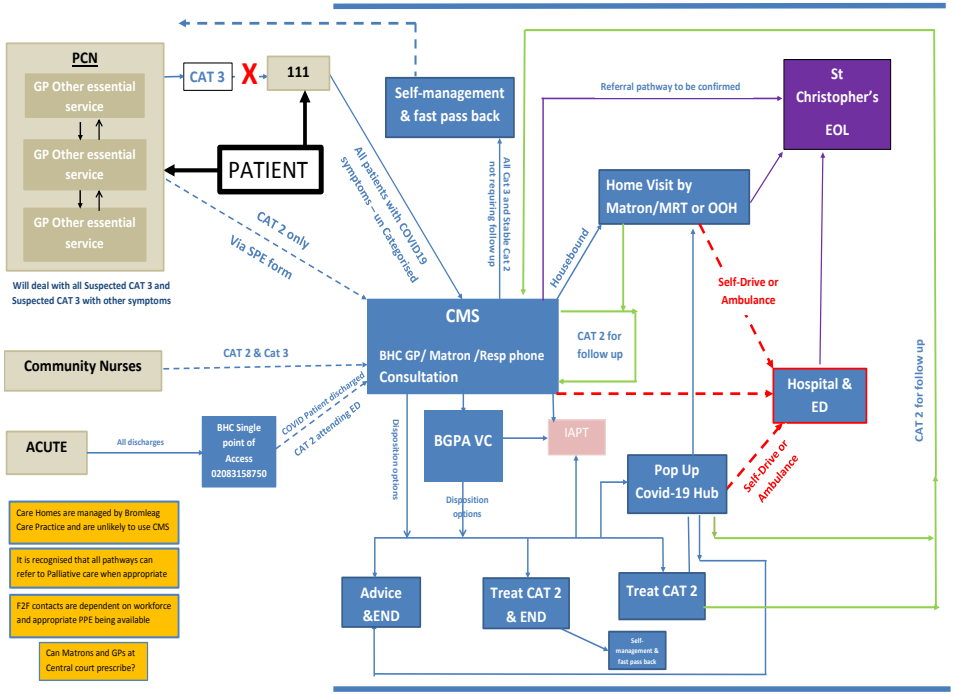
3. Working together: Case Study 2 – Bromley Community Covid Management Service (BCCMS)

Description/Background

BCCMS provides a monitoring and treatment service for any Bromley patient with Covid or suspected Covid symptoms. BCCMS is run by a team of GPs, Community Matrons and managers employed by Bromley Healthcare and Bromley GP Alliance.

Community provision for Covid-19 include:

- Telephone triage
- Ongoing telephone advice
- Respiratory hub (or 'hot hub')
- Home visits where required
- GPs based at Central Court in Orpington to reduce transfer and admin delays



Objectives

- Implement an integrated model and single point of access for Covid patents to be effectively managed in the community
- Provision of a respiratory hub to enable physical assessments in a safe environment
- Provision for Covid patients who are housebound
- Avoid pressure on general practice that could not be safely managed due to PPE, capacity and estates constraints
- Development of an integrated service run jointly by Bromley Healthcare and Bromley GP Alliance, working closely with CCG
- Link the pathways into and out of the PRUH with the BCCMS patient pathway, as well as with End of Life care by St Christopher's

Outcomes & Benefits

1	Direct referrals from 111 , reducing pressure in 111
2	Daily performance reports to measure activity of the service and wider impact
3	Management of patients in the community with limiting escalation into PRUH
4	Multiple methods of contact with patients, through telephone, video conferencing and direct appointments at 'hot' sites
5	Support into Bromley Care Homes
6	Single referral process for Primary Care
7	Reduce pressure in general practice and meet patient demand
8	Positive patient experience

ONE BROMLEY

3. Working together: Case Study 2 – Bromley Community Covid Management Service (BCCMS) - Discussion

Lessons Learnt

- Went well: Strong partnership working to effectively deliver an integrated BCCMS model within a tight timeframe. Smooth transition through the pathway with an effective multi-disciplinary clinical input at the CMS hub to manage presenting need. Excellent feedback from primary care on service referral, model and delivery. Monitoring was clear and readily available.
- Went less well: Flexing capacity between various elements of the jointly delivered service was difficult at times, which meant for a number of weeks, capacity at the GP hubs was significantly underutilised
- Future: Some patients are suffering long-term effects from Covid (e.g. respiratory difficulties) and will need ongoing care. We also need to plan for post Covid services in general practice and support GPs to benefit from the learning of managing these patients in the BCCMS:
    - An education/ training programme is being developed to support and increase knowledge, particularly in primary Care, to effectively manage covid patients in the community.
    - The PRUH respiratory team are running a post covid follow up service for all our patients discharged after Covid. After a telephone consultation, those needing a face to face assessment attend for a one stop clinic. Connections made between the hospital and community service.

What does the service look like over the next 6 months / 1 year

- BCCMS service provision is continuing via the Single Point of Entry (SPE) and a hot hub located in central Bromley
- Continuation of a partnership approach, using the BCCMS provider and commissioner meetings to:
    - Review demand and capacity and refine models of care
    - Managing the reconvening of routine services with the ability to rapidly escalate and flex the BCCMS service depending on potential second wave demand
    - Explore potential to adapt the BCCMS model into a general respiratory community management model, trialled through winter 2020/21
    - Capture feedback from those using the service to help refine and improve the service.

How does the model respond to Escalation in COVID patients/tackle inequalities / other etc..

- Service provides dedicated support to vulnerable groups and patients that are shielding
- Practices have been asked to review their list of shielding patients and to proactively follow up those patients to ensure they are supported
- Emphasis was placed on ensuring End of Life care plans are up-to-date and available on CMC, which the BCCMS contributed to; this needs to continue within general practice over the coming months in preparation for a second wave

3. Working together: Case Study 3 – Care Homes

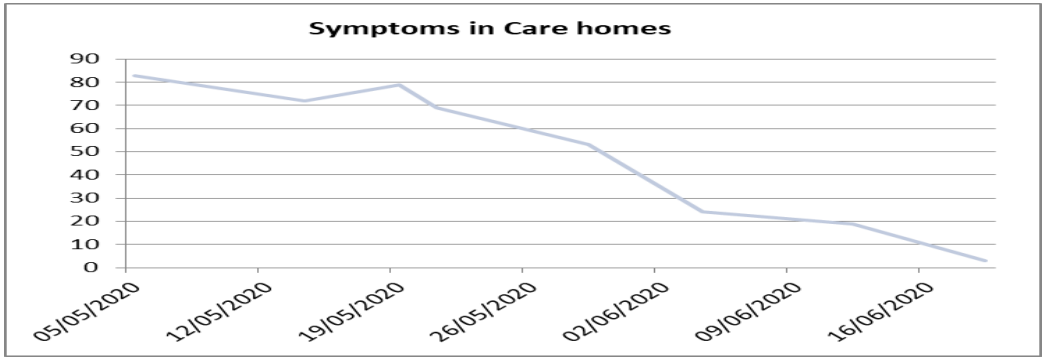
Description/Background

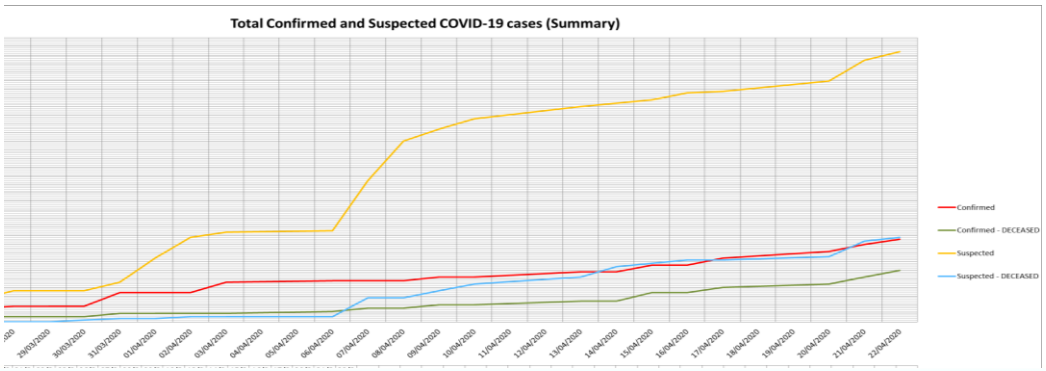
The infrastructure supporting care homes during the pandemic has been more integrated and streamlined across the local authority and CCG. This has led to excellent leadership and support offered to Bromley care homes. Several areas of work have been fast tracked during the pandemic including; and enhanced end of life offer; infection management and control training and support; rehabilitation provision offered within care homes and significant progress on pharmacy, medical cover and clinical leadership across care homes for people with learning disabilities and mental ill health. There have also been further enhancements for elderly and frail residents provided through the Bromleag Care Practice.

Objectives

Provide integrated, enhanced care and support offer to support the sector
Key local operational responses:

- Prioritising the delivery of PPE and clinical equipment
- Ensuring appropriate staffing levels and providing Public Health infection control advice and support
- Testing
- Workforce and clinical support
- Infection Prevention and Control Measures





Outcomes & Benefits

1	Effective programme of testing rolled out with ongoing dedicated support in this area
2	Effective support to care homes around infection control to manage residents safely
3	Improved clinical and specialist input and support to care homes improving quality of care and outcomes for care home residents
4	Excellent, co-ordinated support to the sector enabling providers to maintain provision throughout the pandemic

3. Working together: Case Study 3– Care Homes - Discussion

Lessons Learnt- what has worked well

- Single communication lines to care homes summarising all key information on a weekly basis from across health and social care
- PPE and infection control training - Training on-line – excellent engagement – opportunity to expand on virtual training
- Support to providers via a dedicated line
- Roll out of NHS Mail – majority now in place
- Foundations of MDT for care home support – quality nurse, Public Health – (how we maintain the input from PH), contracts, meds management, dementia support team
- Coordinate My Care (CMC) – worked well, continue to roll out
- End of Life (EOL) care work in care homes has improved
    - Having difficult conversation training from Quality Nurse
    - ECHO training through meds management team and training from St Christopher's
    - St Christopher's delivering EOL care in nursing homes (previously only advisory in residential and Extra Care Housing (ECH)
- Medicines management and pharmacy– ECH during covid which has been extremely beneficial in reducing medicines wastage, optimisation and reducing care calls.
- 3 pharmacists in Bromleag Care Practice (63% of ECH population) 37% other GP practices who are very proactive
- In addition to the enhanced provision delivered through Bromleag Care Practice, CQC-registered specialist care homes (for individuals with learning disabilities, physical disabilities, or mental health needs) now have named clinical leads from primary care. This clinician will provide clinical leadership for the primary care and community health services support to the care home, and is responsible for the co-ordination of service provision to the care home residents.
- Feedback from immedicare is positive
- Single contract for all care home admissions from hospital under Covid19 funding streamlining processes, improving market management and clarity on expectations
- Activity co-ordinator forum with WhatsApp group – excellent peer support – to continue
- Rehab provided in nursing and residential homes with post discharge therapy visit in ECH improving transition and quality of discharge
- Dedicated Care Home liaison within the Transfer of Care Bureau to ensure effective communication on discharge planning and relationships between provider and Trust
- Exemplary approach to providing in-depth support when mobilising Covid19 step-down beds to deliver high quality, safe care home environment underpinned by clinical infection control

Lessons Learnt- what hasn't worked well

- Capacity tracker and PAMMS – 2 systems, created confusion locally
- Lost focus around falls, SLT and TVS main reason for hospital admission
- Initial response to homes was slow as we responded to national guidance and 'ramped up' our approach locally, however significant lessons learnt puts us in a strong position for a potential second wave

What does the service look like over the next 6 months / 1 year

Engage with and respond to CQC direction
Continue to provide a coherent support infrastructure around care homes across the CCG and LA to support and maintain the positive work that has been fast tracked during the period.
Review where we are locally against the enhanced Health in Care Homes Framework and statutory responsibilities
Further develop the clinical leads that have been identified across all homes developing a Care homes clinical leads network/forum to ensure consistent quality
Ensuring sustainability of the market post covid19
Targeting homes with larger outbreaks in the first wave using the model of safe and high quality environments underpinned by clinical infection control management (as per step-down beds)
Ensure that feedback from residents and staff of managing during the pandemic is used to inform future service delivery.

How does the model respond to Escalation in COVID patients/tackle inequalities / other etc..

The approach and support offered to care homes has been essential in supporting homes to respond to Covid19 and will continue in the integrated model targeting support effectively and proactively supporting all homes throughout the period.
Continue with regular commissioner review of demand and capacity review responding as required utilising models and approaches to support the market as per the first phase
Continue to utilise Capacity Tracker to identify homes with symptoms and provide proactive support.
National testing now in place – with good support offered locally in accessing and robust, public health led infrastructure around Covid19 hospital discharge

3. Working Together: Key Messages

10 Key Messages

The Covid19 pandemic has highlighted key themes for us in terms of lessons learned, the way we have worked and how that impacts on our continued plans and priorities. We have identified 10 key messages that must be built upon and become the foundation for the news business as usual for the health and wellbeing of Bromley residents.

1. **Collaboration** – In Bromley, we have a strong history of working in collaboration in partnership between the One Bromley organisations. This is something our staff across Bromley have taken to extremely effectively. Those existing relationships have been key to providing an effect response to the Covid crises, and will be continued to be built upon to strengthen and encourage further collaboration across an ever more diverse suite of initiatives.

2. **Inequalities** – The effect of inequalities on peoples health and wellbeing is not a new concept and has always been a key priority of Bromley's organisations. However, the pandemic has brought into sharp focus the devastating effects inequalities can have. We are now planning for deeper analysis to support our programmes of work in reducing inequalities and improving outcomes. This commitment will be underpinned by close collaboration across teams and work streams to inform strategic decisions and wave 2 preparations.

3. **Intelligence** – Teams across Bromley and South East London have been working closely in the sharing of information and best practice. This is a process that has been repeated nationally with an unprecedented ethos of sharing. This is a concept that we must continue to embed into our organisations and become champions of. The open sharing of intelligence will be crucial to improving the wellbeing of our residents and achieving our individual and cross organisational priorities.

4. **Communications and engagement** – Communications and Engagement has been central to our Covid response, for both patients and residents and our own organisations staff. Our communications and engagement recovery plan is built Upon engagement on our transformational plans and priorities, and capturing the real world lived experience of our residents throughout the pandemic.

5. **Staff health and well being** – Building upon our robust communication plans, our staff across organisations have had a continual package of support to enable them to not only safely and effectively complete their tasks, but also to ensure their physical and mental wellbeing. Staff have had access to a wide variety of schemes and initiatives to ensure wellbeing and an ambitious programme of remote working has been incredibly successfully undertaken.

3. Working Together: Key Messages

6. **New ways of working** – New ways of working, hasn't been limited to remote working and the increased utilisation of virtual conferencing. We have seen fast passed change in response to the pandemic, across clinical pathways and locations. As touched upon in our 3 case studies; The Single Point of Access has seen clinician to clinician phone calls to refer to ALL community services streamline discharge pathways. Bromley's Community Covid Management Service has a smooth transition of patients through the pathway with an effective multi- disciplinary clinical input. Bromley's Care homes have benefitted from dedicated Care Home liaison within the Transfer of Care Bureau to ensure effective communication on discharge planning and relationships between provider and Trust.

7. **Leadership** – The Covid response has required strong and decisive leadership across Bromley. Emergency response structures were in place quickly and that has led to a flexible and mobilised workforce. The triple leadership of One Bromley, its individual organisations and that of the South East London CCG and ICS has meant that planning, data gathering, communications an decision making has been dealt with dynamically and efficiently with appropriate scrutiny. The One Bromley health and care response contributed to the London Borough of Bromley's local leadership across social and economic recovery from Covid.

8. **Organisational change** – The strong leadership and willingness for collaboration of our staff has shown a need to review organisational change and how we now approach business as usual. We have shown much resilience and resourcefulness in our response to Covid and now we must look at how our processes and collaborations can be streamlined further for benefits realisation. We must also strengthen our infrastructure, supporting population health initiatives, staffing and new ways of working.

9. **Innovation** – The covid epidemic has had a significant impact on One Bromley agencies, meaning services, planning and organisations have had to adapt quickly and efficiently. This has led to innovation across our sector which must be harnessed and expanded to give new ways of working and new ways of delivering services and accessing care. This has been underpinned by a digital revolution that commenced before the global pandemic, but that has been rapidly utilised and embedded. Through engagement with stakeholders and communities, we have an opportunity to innovate further for the benefit of our staff and residents, be that digitally, through innovations in workforce models, or entire rethinks on service previsions.

10. **Voluntary Involvement** – The existence of the well established Bromley Third Sector Enterprise (BTSE), representing the major voluntary organisations in the Borough, working as part of One Bromley, was a significant positive factor in our response to the Covid. The co-ordinated input of the third sector into the hospital discharge process as part of the SPA was invaluable, supporting patients to settle at home. The BTSE played a key role in supporting many services across the Borough and in brining services back online. The wider support of the voluntary community at large, with over 1,000 mobilised volunteers providing assistance to shielded residents demonstrated the capacity of the community to contribute to the helping those who require it. Co-ordinated through the London Borough of Bromley and Community Links Bromley, this is a valuable resource we should continue to build upon in the future.

4. Planning for Recovery : Priorities – One Bromley Work streams (1 of 2)

➢ Urgent Care	➢ Reporting to the A&E Delivery Board ➢ Winter Planning and contingencies for future spikes in Covid ➢ Continuation and development of the Single Point of Access
➢ Frailty	➢ Working through the Frailty Task & Finish Group & optimising the proactive care pathway ➢ Developing the frailty service across the hospital and community ➢ Supporting patient identification
➢ Mental Health	➢ Through the Mental Health Strategic Partnership Board ➢ Taking forward the Bromley Mental Health and Well Being Strategy ➢ Develop primary care offer ➢ Providing early intervention community support ➢ Develop a holistic community intervention and support service ➢ Develop an integrated recovery and rehabilitation pathway
➢ Elective Care	➢ Working with the PRUH across the system as part of South East London in prioritising next areas of transformation ➢ Supporting clear communications to patients on services available
➢ Children & Young People	➢ Developed through the Children's and Young People Programme Steering Group ➢ Digital first approach & virtual clinical appointments ➢ Winter planning and pathways in place for C&YP with possible covid or respiratory symptoms ➢ Capacity for acute & emergency care including the setting up of a Hospital @ Home model ➢ Community Services, vulnerable C&YP, including safeguarding ➢ Screening & prevention (this could include a MASH presence) ➢ Strengthening multi agency working ➢ Managing current & future demand & capacity ➢ Focus on the transformation of CAMHS services across all settings from acute to community

4. Planning for Recovery: Priorities – One Bromley Work streams (2 of 2)

➢ Long Term Conditions	➢ Includes Diabetes through the Diabetes Partnership Group ➢ Review of services, particularly in light of lessons learned from the impact of the Covid pandemic ➢ Virtual access for diabetes education and pre diabetic education ➢ Support community providers to deliver diabetes interventions and work with APCP ➢ Identify PCN diabetes leads ➢ PodWard Clinic to be implemented at the PRUH
➢ Care Homes	➢ Led through the Care Homes Board ➢ Taking forward the actions set out from lessons learned through the Covid pandemic ➢ Wide ranging programme of work across Health and Social Care
➢ Medicines Management	➢ Working with South East London Medicines Management Teams in developing priorities to be implemented locally
➢ End of Life Care	➢ Re-establishment of the End of Life Steering Group ➢ Working with partners including St Christopher's to ensure services build on the integration with other services across Bromley ➢ Taking forward previous plans to increase Co-ordinate my Care utilisation in Bromley
➢ Ageing Well Accelerator Site	➢ Urgent Community Response - Introduction of 2 hr access standard to crisis support and 2 day for intermediate care. ➢ Part of SEL wide programme ➢ Funding (£2m) and tailored support package (site visits, face to face meetings, master classes, webinar, peer reviews)

4. Planning for recovery: Urgent Care

Description

Building on the lessons learnt from covid19 and considering the new landscape, a clear plan on how the urgent and unplanned care system will meet the needs of key vulnerable groups in the context of a second wave of Covid19 and winter pressures. The key focus will be on providing community based care that prevents the need for hospital attendance and admission especially for vulnerable and high risk groups.

Key Priorities

- Focus on developing winter plans in all areas, including preparing for a potential second wave of Covid19
- Expanding the Primary Care Covid19 Management Service (CMS) to include wider exasperation of respiratory conditions
- Acute patient flow and Transfer of Care
- Maintaining the Single Point of Access (SPA)
- Mobilise hospital @home targeted at vulnerable groups
- Implementation of Help us Help You to support the reduction of ED and UTC walk in attendances, offering booked appointments and alternative services

Impact on inequalities

- Reducing hospital admission for vulnerable groups
- Winter planning to focus on prevention and management of second outbreak with a focus on vulnerable groups
- The Primary Care Flu Working Group are considering the most effective and innovative way to manage flu vaccinations for vulnerable groups building on learning from covid19 and utilising Primary Care Networks

Milestones & Timescales

Milestones	Timescales
1. Set up task and finish groups with key partners to scope and define the model	July 2020
2. Review the system plan to ensure coherent and communicate to all partners	Aug 2020
3. Mobilise	Sept 2020

Key Risks

Key Risks	Mitigation
1. Workforce	Continue to ensure maximum support to the workforce including PPE and testing Consider mutual aid and prioritisation of how to use the workforce considering those that are not able to provide face to face contact
2. Capacity to mobilise due to significant pressure in day to day delivery	Urgent Care lead to take on a role with protected tome to lead the system working in this area, utilising existing meetings to engage partners
3. Clinical buy in	Engaging clinicians early and using covid19 learning and data to inform these discussions

4. Planning for recovery: Ageing Well Accelerator Site

Description

Introduction of 2 hr access standard to crisis support and 2 day for intermediate care.
7 national accelerator sites selected following an application process
Part of South East London wide programme
Funding (£2m) and tailored support package (site visits, f2f, master class, webinar, peer reviews)

Key Priorities

The objectives of the programme are to

- Determine a national operating model.
- Codify the data detail behind the national standards.
- Develop a workforce model.
- Share good practice across England.
- Buddy with a non-accelerator site.

Impact on inequalities

- Create a more responsive urgent care response model to meet the needs of the vulnerable population in Bromley
- Modelling of demand and capacity will consider in socio-economic and demographic factors so that services will take into account local inequalities
- Services and support will be more tailored to meet the needs of local populations

Key Risks

Key Risks	Mitigation
1. Demand and capacity modelling required at borough level to inform local service planning.	Working with One Bromley partners to develop a community demand and capacity model supported by the SEL team

Milestones & Timescales

Milestones	Timescales
Data and workforce modelling; logistics; recruitment; digital competency; e-scheduling detailed work	Q1/2 2020-21
All accelerator sites live with full model and reaching the standards	Q1 2021-22
Accelerator learning published	Q1 2023-24

4. Planning for recovery: Frailty/Proactive Care

Description

- Improve collaborative working (across secondary, community, primary, mental health, social care & third sector) for patients that are frail and/ or have complex long term conditions that need extra support to keep well and reduce the number of crisis episodes
- Streamline the frailty & proactive care pathway using One Bromley as a platform to enable better integration of pathways across providers
- Strengthen primary and community provision and reduce hospital admissions
- Focus on prevention, identification and management of typical frailty patient conditions. This includes early identification of eligible patients, either in primary/ community care as step up or across from PRUH A&E
- Strengthen the discharge pathway to offer suitable care outside of the hospital environment and provide a safety net.

Key Priorities

- Optimise Proactive Care Pathway with closer alignment with Frailty
- Community Frailty Ambulatory service
- Hospital/ front door frailty identification/ MDT and assessment
- Implementation of an ambitious frailty programme in development with the PRUH and aligned with community services. This is also linked to the development of a Virtual ward

Impact on inequalities

- To support the frail elderly population and those with complex long term conditions in a more integrated and coordinated way, both in and out of hospital. This will be the cohort of patients that are shielding or vulnerable to Covid19
- Identified as a priority to support patients in the community and reduce unnecessary admissions & LOS in the hospital (to also include NHS111 pathway for patients needing urgent care – Help us help you)
- Ability to flex the work force to support COVID management services in case of second wave

Milestones & Timescales

Milestones	Timescales
1. Streamlined Proactive care pathway re-opened	**July 2020**
2. Systematic approach to patient identification and case management (Proactive care)	**Oct 2020**
3. Pilot a Frailty Ambulatory service model	**Nov 2020**
4. Front door frailty assessment/ MDT & assessment	**Nov 2020**
5. Development of a Virtual ward- frailty programme across secondary and community care	**TBC**

Key Risks

Key Risks	Mitigation
1. Workforce/ recruitment	To look at workforce/ skill mix across the system to address challenges in recruitment and retention
2. Identifying/ pulling appropriate patients onto the frailty pathway	New models of care to focus on appropriate patients for the frailty pathways
3. Increasing pressure on the PRUH and managing winter challenges	New models of care to focus on community based provision
4. Frailty index	Beneficial to have an agreed definition of frailty across the system - currently have Rockwood, Edmonton and GP Frailty index.

4. Planning for recovery: Mental Health

Description

- The Bromley Mental Health and Wellbeing Strategy has a focus around prevention, early intervention and recovery. An annual action plan is currently being refreshed in light of the new situation following the covid-19 lockdown.
- There have been some opportunities with the covid-19 situation, with a shift of many services online, and a greater focus on ensuring people are able to stay safe living in the community and do not require hospital services unnecessarily.
- There are significant opportunities in Bromley to integrate primary and secondary mental health services.

Key Priorities

- Develop an enhanced primary care offer for mental health in Bromley
- Enhance the voluntary sector prevention and early intervention service for mental health
- Prioritise housing, employment and independent living as part of the recovery journey for individuals
- Transformation of outdated housing services with a new focus on reablement, skills and independence.
- Develop a joint voluntary sector/NHS model for children and young people's mental health and wellbeing.
- Increased talking therapies provision to support individuals with long term conditions, alongside anxiety and stress.
- Improved support for people with dementia in the community.

Impact on inequalities

- The shift away from hospital to community services has better enabled people to stay living independently in their own home. There remain challenges in supporting all communities in the borough, and an enhanced primary care mental health offer will better enable the targeting of hard to reach groups.
- A new Children and Young Peoples Wellbeing Service will focus on communities at risk, including Black, Asian and minority ethnic.

Milestones & Timescales

Milestones	Timescales
1. Bring forward a long-term enhanced primary care offer for mental health in Bromley, building on the learning from the shared care pilot.	2020/21
2. Transformation of recovery pathway with a new housing/floating support offer.	2020
3. Refresh of prevention/early intervention offer	2020

Key Risks

Key Risks	Mitigation
1. Lack of capacity across CCG and LBB commissioning to deliver the Mental Health and Wellbeing Strategy at this time.	Early stages of planning for the development of a single LBB/CCG single commissioning team, which will include a strong focus on mental health commissioning.
2. The level of interest in the strategy remains high with a very large number of different stakeholders each with their own visions on the future of mental health provision.	Ongoing consultation and engagement on the strategy through a number of for avenues.
3. Ongoing challenges across the mental health system, including increasing levels of pressure on CAMHS services	Development of a CAMHS transformation plan to meet the needs of an improved children and young people's offer, informed by a review led by NHS Improvement.

4. Planning for recovery: Elective Care

Description

- Improve integrated working and collaboration on outpatient pathways across secondary, community, primary, mental health, social care, third sector, service users and carers. This is to focus on integrating current service provision.
- Improve the outpatient pathway using One Bromley as a platform to enable better integration of pathways across Bromley providers
- Strengthen primary and community provision and reduce hospital activity
- Integrate outpatient pathways with community and primary care services to offer suitable care outside of the hospital environment and closer to home
- Strengthen expert consultant support to community providers including GPs
- Reduce inappropriate referrals into outpatient and delays in treatment
- Improve the Trust's outpatient national performance figures
- Increase virtual video and online outpatient appointments while reducing face to face appointment where clinically safe to do so.
- Improve patient experience of the outpatient pathway
- Work as part of the SEL ICS and Acute Provider collaborative focusing on ophthalmology, general surgery, trauma and orthopaedics and urology.
- Recovery plans for cancer pathways and focus on resourcing diagnostics, in particular endoscopy, and CT.

Key Priorities

The first 4 specialties which tied in with work already underway were:

- Cardiology
- Haematology
- Rheumatology
- Paediatrics

Impact on inequalities

Patients able to be seen as outpatients in more convenient locations and more convenient times making outpatient care more accessible to a diverse population

Milestones & Timescales

Milestones	Timescales
1. Outpatients to return following the temporary shut down due to the pandemic	Jul 20
2. Reset and recovery plans for outpatients to be published	Oct 20
3. Delivery of reset and recovery plans for outpatients	Jan 21

Key Risks

Key Risks	Mitigation
1. No OPT Programme Lead	Consideration of the priorities going forward
2. COVID reset and recovery planning just returning outpatients to business as usual	OPT Lead to link in with Trust reset and recovery groups to try to influence planning Work closely with the Kings outpatient transformation programme.

4. Planning for recovery: Children & Young People (In Integrated Care)

Description

- Focus of the C&YP programme to change from strategy/transformation to more direct tactical support and development to enable services to be resilient and sustainable in the short to medium term. This will include taking the learning and new working practices that have emerged through the pandemic and embedding them into business as usual. This will enable:
- Effective management in potential surge in demand for services post the lockdown, or to respond if there are further waves of covid-19 later in the year
- Working on a number of cross cutting themes to structure the next phase of work around - e.g. digital first/virtual working; vulnerable children & safeguarding; acute/community caseload management; multi-agency working; prevention/imms & screening; mental health & wellbeing
- C&YP programme to also include young adults (0- 25 years). This is to acknowledge that the a number of young people transitioning to adult services (18-25 years) are particularly vulnerable and reflects feedback from young people and families.
- To build on the range of approaches used to engage with C&YP and families.

Key Priorities

- Digital first approach & virtual clinical appointments
- Winter planning and pathways in place for C&YP with possible covid or respiratory symptoms
- Capacity for acute & emergency care including the setting up of a Hospital @ Home model
- Community Services, vulnerable C&YP, including safeguarding
- Screening & prevention (this could include a Multi-Agency Safeguarding Hub (MASH)presence)
- Strengthening multi agency working
- Managing current & future demand & capacity
- New Health Visiting Service

Impact on inequalities

- Integrated hospital/community health offer and H@H model to support children and young people that are acutely unwell
- New Health visiting service to ensure babies are thriving and early years services support vulnerable children

Milestones & Timescales

Milestones	Timescales
1. Implementation of a Hospital @ Home model	Nov 2020
2. Development of a winter C&YP primary/ community care model	Oct/ Nov 2020
3. Pathway in place for C&YP with potential covid/ respiratory symptoms in place as part of winter planning	Oct/ Nov 2020

Key Risks

Key Risks	Mitigation
1. Clinical and project management capacity	To refocus work around priority initiatives over the next 6 months.
2. Resources for service developments	It is recognised that additional resources are significantly constrained and 'bids' for C&YP initiatives will be in competition with those from other service areas.

4. Planning for recovery: Children & Young People (In SEND)

Description

- Delivery of education and health care service for children and young people with special educational needs and disabilities (SEND).
- In the consideration of the opening of schools and the return to normal practice in relation to the childrens and families acts 2014.
- Joint work across the CGG and Bromley council in order to fulfil the duties for children and young people with SEND
- Support the restoration of community health services for SEND
- To work with children and young people and families to ensure the effective delivery of education health and care plans (EHCPs)

Key Priorities

- Restoration of SEND community health services including schools as they reopen
- Transformation of therapies offer in particular Speech & Language Therapy and Occupational Therapy
- Delivery of an enhanced community nursing service in special schools
- Restoration of ASD & ADHD assessment pathways
- Delivery of new integrated wellbeing service for children and young people across the CCG and council
- Reshaping community mental health offer with shorter waits
- Return of mental health support teams in schools following schools reopening

Impact on inequalities

- There has been a differential impact on children and young people, in particular through the period of school closure; some children and young people have not been able to access the education, health and care services that they require
- Concern over childrens physical and mental health as services reopen with a potential surge in demand
- Some services continue with a digital offer, however issue of digital inequalities for children and young people unable to access online offer

Milestones & Timescales

Milestones	Timescales
Schools reopening/many SEND services recommencing	Sept 2020
Review of Speech & Language & Occupational Therapy	Dec 2020
New children and young people wellbeing service procured	Dec 2020

Key Risks

Key Risks	Mitigation
Changes to in school environment impacts on service delivery	Joint work across council, CCG & schools to deliver a modified offer
Demand for education, health and care services is greater than capacity	Ongoing review of service demand across providers, council and CCG. Engagement with children and young people and families to support access and meet needs
A greater call on specialist services due to universal targeted offer not meeting needs	Redesign of universal targeted offer to ensure balanced approach across services

4. Planning for recovery: Diabetes

Description

- Promote diabetes prevention programme- NDDP. Referrers to promote benefits of virtual education to encourage uptake.
- Improve collaborative working, ensuring mental health services are integrated.
- Ensure practices have a functioning call and recall system to drove identification, prevention and management for pre diabetics and Type 2.
- Support across primary care to enable more people to achieve the recommended diabetes treatment targets and drive down variation between CCGs and practices.

Key Priorities

- Virtual access for diabetes education and pre diabetic education
- Support community providers to deliver diabetes interventions and work with APCP
- Identify PCN diabetes leads
- PodWard Clinic to be implemented at the PRUH

Impact on inequalities

- To support the pre diabetic and diabetic population in a more integrated and coordinated way. Diabetic patients particular are clinically vulnerable to Covid19, and this should be taken into account when considering interventions
- Commission required amount of virtual education capacity in lieu of classroom courses
- Look at the community diabetes contract in light of the changing landscape and education provision

Milestones & Timescales

Milestones	Timescales
1. Commission online spaces for diabetes education	Oct 2020
2. Submit NHSE Treatment and Care strategic plan for Bromley	Jul 2020
3. Academic half day event – diabetes	Sept 2020
4.Consultant diabetologists and inpatient diabetes specialist nurse led discharge clinic to be implemented at PRUH.	Aug 2020
5.Plans for Freestyle Libre, general support to community provider in changing service provision	Sept 2020

Key Risks

Key Risks	Mitigation
1. Lack of face to face education, and patient appetite to take online education	Availability of online courses and other means
2. Understanding the impact of covid 19 for those with diabetes	Engagement with diabetes patients to inform future plans
3. Unable to continue FSL mobilisation due to no group starts and f2f appointments	View alternatives with provider
4. Access to bloods for patients	Potential to use BGPA phlebotomy

4. Planning for recovery: End of Life

Description

End of life (EoL) care is an important part of Palliative care for people who are considered to be in the last year of life. It is a holistic form of care which aims to help people live as well as possible and to die with dignity. It also refers to treatment during this time and can include additional support, such as help with legal matters along with support for families and carers throughout the last phase of the patient's life and into bereavement. End of life care crosses a vast number of Commissioned services from multiple Providers, where there is a need for a cohesive and seamless service provision for the patient.

Key Priorities

- Establish End of Life Strategy for Bromley residents, in line with National and South East London (SEL) planning.
- Ensure Providers are aware what elements they are commissioned to delivery, how any cross over provision is managed and there is joint and seamless working between Providers .
- Engage with and implement CMC.

Impact on inequalities

- To support the population of Bromley that are in the final year of life in a more integrated and coordinated way, both in and out of hospital. This includes the cohort of patients that are shielding or vulnerable to Covid19.
- Identified as a priority to support patients in the community, care and nursing homes and hospices to reduce unnecessary admissions and length of stay in the hospital.
- Ability to flex the work force to support COVID prioritised services in case of second wave.

Milestones & Timescales

Milestones	Timescales
• Re-establish EoL Steering group.	Sep 2020
• Review commissioned and contracted services for EOL with a view to clarify and streamline.	Dec 2020
• Link with SEL planning on EOL strategy (including CMC).	Aug 2020

Key Risks

Key Risks	Mitigation
1. Clinical and project management capacity for review of commissioned services	To clarify requirement at steering group and identify work-plan to enable key stakeholders to refocus work around priority initiatives over the next 6 months.
2. Providers may not agree on how the services are commissioned from each provider or how a realistic cross over will work along with impact on provider finances.	One Bromley approach – clear rationale on proposed changes, ratified at One Bromley Exec.
3. SEL strategy may not prioritise in-line with local need.	Ensure Bromley voice at SEL group and identify scope for setting local strategy (that is aligned to SEL).

4. Planning for recovery: Care Homes

Description

The infrastructure supporting care homes during the pandemic has been more integrated and streamlined across the local authority and CCG. This has led to excellent leadership and support offered to Bromley care homes. Several areas of work have been fast tracked during the pandemic including; and enhanced end of life offer; infection management and control training and support; rehabilitation provision offered within care homes and significant progress on pharmacy, medical cover and clinical leadership across care homes for people with learning disabilities and mental ill health. There have also been further enhancements for elderly and frail residents provided through the Bromleag Care Practice.

Key Priorities

- Progressed integrated, multi-disciplinary enhanced care and support for Care homes and residents
- Significant developments in clinical support including
- Providing single lines of communication and virtual training

Impact on inequalities

- The approach and support offered to care homes has been essential in supporting homes to respond to Covid19 and will continue in the integrated model targeting support effectively and proactively supporting all homes throughout the period.
- Continue with regular commissioner review of demand and capacity review responding as required utilising models and approaches to support the market as per the first phase
- Continue to utilise Capacity Tracker to identify homes with symptoms and provide proactive support.
- National testing now in place – with good support offered locally in accessing and robust, public health led infrastructure around Covid19 hospital discharge

Milestones & Timescales

Milestones	Timescales
1. Formalise MDT holistic support around Care homes	July 2020
2. Agree focus of care and support over winter and phase 2 maintaining infrastructure and support that has been provided during covid19	Aug 2020

Key Risks

Key Risks	Mitigation
1. Integrated working	Utilising good relationships from covid19, developing shared objectives
2. Workforce	Refocus priorities of some provision to ensure available capacity
3. Engagement of care homes and clarity of purpose	Maintaining clear lines of communication and offering timely, tangible support to homes.

4. Planning for recovery: Medicines Management

Description

- QIPP savings priorities must remain responsive to fragility in supply chains. Focus on safety and quality is paramount during recovery.
- Digital solutions even more important to improve efficiencies & safety e.g. EPS, eRD, eclipse live, NHS app for ordering medicines
- Accelerate integration of community pharmacies into local healthcare services via lead PCN community pharmacist e.g. vaccine program
- Facilitate new models of care including remote outpatients, prescribing and consultation models. Remote FUs, improved shared care.
- High Cost Drugs, focus on clinical and financial outcome frameworks via IMOG/APC & reference price approach.
- Role of pharmacy in developing ICS locally and SEL wide

Key Priorities

- Medicines QIPP – refresh plans, borough implementation key players.
- Working collaboratively with PCN CDs to support patient needs
- Structured Medication Reviews in PCNs, EHCH proactive care
- Amplify collaboration across all stakeholders in SEL & outcomes focus
- integrated pharmacy to enable leadership, access to specialist skills and to support digital consultations & medicines prescribing & supply.
- Improvement- Advance Care Planning & Palliative Medicines Services
- Self management and development of digital structured education
- SEL antimicrobial resistance group, guidance and work plan
- Mental health pathways and guidelines, integrated with borough MH priorities.

Impact on inequalities

- Improved access to safe, effective medicine for higher risk patients who have not routinely/ recently accessed health care and monitoring
- Improved physical health management in MH patients
- Improved access to healthcare from variety of clinicians/locations

Milestones & Timescales

Milestones	Timescales
• Form borough medicines implementation group	Oct 2020
• Commence implementation of revised QIPP plan post PCN annual prescribing reviews/ agreements	Oct 2020
• Recruit to gaps in team in order to meet key priorities	Oct 2020
• Install, train and optimise digital solutions	Jan 2021
• Develop resource tools/training to support DES SMRs	Oct 2020

Key Risks

Key Risks	Mitigation
1. Achieving QIPP financial targets will be compromised	Re-prioritise high impact, quick wins. Optimised clinical outcomes & reduced morbidity reduce NHS burden but not fixing £
2. Significant gaps in MO team with long term sickness & maternity leaves	Recruit to vacancies plus 8b sick leave cover asap
3. Work plan co-dependent e.g. on borough MH commissioning, care home board, PCN CDs, conflicting clinical primary and secondary care priorities	Collaborative working. Integrated approach across borough, place based, SEL CCG and developing ICS.

Emerging from Covid-19 in Bromley:
Recover and Aspire

Vision statement:

Bromley primary care will recover from the negative impacts of the Coronavirus pandemic in a well-considered and timely manner that engages productively with key stakeholders and supports our population and the wider healthcare system. Our aspirations for Bromley as outlined through our General Practice Strategy and related One Bromley plans, remain unchanged and we will utilise the opportunities presented by Covid recovery to deliver high quality, accessible and collaborative care for all Bromley patients.

About this plan:

This summary outlines the work streams that will form part of Bromley's recovery plan. This is a primary care recovery plan but will link significantly with other areas of healthcare and with other partners in the local and SEL healthcare system. The plan also covers proposed governance, engagement, finances and timescales at a high level; these will be refined as we start 'doing the doing' and understand the scope of the tasks better. These groups by themselves will not get everything done to recover and build on gains and aspirations across Bromley. They are intended to provide the coordination, leadership and review of ongoing work across the system. This structure will provide assurance to and direction based on feedback from the various senior leaders and governance routes in Bromley and SEL.

4. Planning for recovery: Primary Care

Bromley work stream	Description and rationale	Included in scope	Links and inter-dependencies
A. Covid management 2.0	Retain resilience to step up Covid management in the community for a second wave. Prepare to shift Covid care into the mainstream and support practices to operate under new conditions.	• Evaluate BCCMS • Retain BCCMS provision while balancing value for money • Link with education networks to share learning with general practice • Ensure general practices are equipped to manage Covid, and increase confidence of practices to resume seeing patients face-to-face • Oximeter distribution and management • Exclusions: Acute Covid management • Prevention of outbreaks and general outbreak management as outlined in Bromley Outbreak Control Plan.	Links into SEL primary care recovery work stream on this topic. SEL respiratory clinical advisory group. Links with Public Health (Jenny Selway)
B. Recovery proper	Catching up on the backlog of work missed and the additional demand from patients generated as a result of Covid-19, lockdown or similar.	Managing consequences for patients, such as: • Poorer mental health • Increased domestic violence • Outcomes of delaying care, e.g. 2ww • Backlog of LTC and meds reviews • Backlog of diagnostics • Post-discharge support for Covid patients	Dependant on hospital outpatients, 2ww, IAPT and diagnostics services fully restarting and clearing their backlogs. Must link with local and SEL preparations.
C. Health inequalities, clinical effectiveness and public health priorities	The recovery journey will need to reverse negative health and life outcomes exacerbated by Covid, and analyse longer term population healthcare needs and opportunities for improvements in line with likely future PCN DES requirements.	• Catch up the overdue screening and immunisations backlog • Catch up other public health services, such as sexual health, obesity, smoking, LD Health Checks, and patient self-care • Ambitious winter flu programme • Reduce MH inequalities and increase SMI health checks • Increase in hardship and non-medical problems such as housing, debt and relationship breakdown	Population healthcare management is somewhat nebulous and will need to link into SEL work streams / pilot. Health inequalities and Public Health priorities to be lead by Public Health (Gillian Fiumicelli) PMS Premium. Social prescriber workforce.

4. Planning for recovery: Primary Care

Bromley work stream	Description and rationale	Included in scope	Links and inter-dependencies
D. Proactive care and LTC management – *building on existing proactive care pathway groups*	The proactive care pathway can be adapted to better support practices to manage the most vulnerable patients, and return to the right level of care based on clinical need.	• Review all shielding patients to give the right advice and care for their individual situation emerging from Covid • Recovery and embedding enhanced care in all care homes • Fortifying End of Life care arrangements, care planning and utilising CMC	Dependency on One Bromley partners and existing work stream. PMS Premium. Link with SEL work stream.
E. Consolidating gains and building resilience in general practice	Covid-19 has led to accelerated adoption of lots of valuable ways of working and technologies that were in our strategic plans to adopt in the longer term. These must be maintained and built upon where beneficial, including for a second wave.	• Maintain and further digital enablement and data sharing • Maintain total triage to balance practice footfall, estates pressures, inefficiency, etc. • Manage urgents differently, such as new models for home visiting and new roles • Also includes improving support for staff wellbeing and resilience	This will need to link with the SEL Digital work stream, via Jess Seal.
F. Primary care 2.0	Prior to Covid, primary care was embarking upon significant transformational change to address entrenched workforce, workload and resilience challenges. Recovery from Covid offers an opportunity to secure a sustainable future for practices.	• Ongoing development of PCNs to deliver the promise of collaborative working both between practices and with One Bromley providers • Optimising new roles and workforce within an improved model of primary care • Tackling estates challenges and opportunities arising from Covid	This group will cross-cut several of the other proposed recovery work streams. PCN development funds. Patient engagement to inform transformational changes and recovery

Emerging from Covid-19 in Bromley: Next steps

Process and engagement

- Feedback from PCN CDs actively sought and incorporated into draft – PCNs to be represented on every group
- Submission of a draft to SEL Bronze Command and feedback received and incorporated
- Cross-referenced for linkages to London, SEL and HLP principles. Several groups will need to link closely to SEL work streams
- Proposals to be shared with Bromley LMC, BGPA as the GP federation and One Bromley partners including LBB for comments and representation on some groups where applicable
- Proposals to be shared with virtual cluster meetings and Locum and Salaried Group in early July
- Patient engagement requires further consideration

Commencement, review and finish

- The groups should be convened as soon as possible, particularly those work streams where there is a risk that as Covid subsides, practices slip back into old ways of working
- Once we have agreement with a critical mass of key stakeholders, including PCN CDs, LMC and practices (though the cluster meetings), we can establish this as our recovery plan and commence work through the group leads
- Review will need to be regular to hold the groups to account for achieving their aims – suggest this is at least monthly
- These are tasks and finish groups and therefore part of the ongoing review will be to evaluate the ongoing need for the group. These will be stood down once aims have been achieved

Governance

- A balance needs to be struck between 'getting on and doing' with good governance and an appropriate level of oversight by senior officers and clinicians
- We will report into existing governance structures as appropriate to the work stream, including the Bromley Borough Based Board, SEL PCCC and local primary care operational group, One Bromley Executive and working groups

Costs and funding

- The groups will draw resources primarily and wherever possible from existing funds
- No allocated budget is available to groups for recovery, although funding may be available to some of the work streams where these are part of ongoing spend, e.g. SEL pilots, PMS Premium, PCN development
- Backfill costs for clinical members to participate may be considered by the CCG

4. Planning for recovery: Wider Priorities / LBB

London Borough of Bromley's Recovery Strategy supports borough-wide social and economic recovery

- **Restore – Post Lockdown**
  - Understanding and reflections – log of key decisions, narratives on statutory services, baseline of finance, risk logging
  - Decommission response services
  - Re-establish critical services and then non-critical services
  - Response to surge in immediate increase in service demands (potential increased demand due to domestic violence, mental health, rough sleeping, serious youth violence, safeguarding, crime, Adult Social Care and discharge, welfare dependency, unemployment)
  - Facilitate the social and economic recovery of Bromley –new relationships with businesses
  - Restore (an updated set of) council services, democratic processes, project delivery and financial sustainability
  - Readiness for potential Covid-19 Wave 2 in autumn 2020
- **Reinvent**
  - Take opportunities for Council and civic society to enhance and improve the borough
  - Review, update and embed organisational change
- **Retain**
  - Recognise effort and commitment of staff & community during crisis
  - Support the healing process, following the loss of friends & colleagues
  - Recognise the skills people have gained & support change
  - Ongoing use of remote and agile working

4. Planning for recovery: Borough-wide Priorities

Strategic Theme	Restore	Reinvent	Retain
People	➢ Supporting staff out of lockdown ➢ Managing additional service demand – domestic violence, mental health, etc.. ➢ Review continuation of Covid helplines	➢ Develop agile working ➢ Increase online capability ➢ Review staff travel plans ➢ Recognises and reward Covid support	➢ Sense of common purpose for transforming services ➢ Online staff meetings ➢ Continue Public Health Covid advice
Place	➢ Recovery of town centres and markets ➢ Pedestrian flow and social distancing	➢ Rethink public spaces to enable movement of people and social distancing ➢ Support return to business	➢ Encourage continued use of parks and public spaces for exercise ➢ Ensure effective transport hubs and safe walking and cycling
Accommodation	➢ Reopen Council buildings for staff ➢ Reopen Council buildings for public ➢ Ensure online access to work and services	➢ Review of DSE assessments and other occupational health requirements ➢ Improved website information quality and accessibility	➢ Rollout new technology solutions e.g. online conference call capability ➢ Virtual decision making (committees, panels, hearings) ➢ Increased digital public services where implemented as a result of Covid
Finance	➢ Review budgeted income streams and identify impact on loss of income through ceased or deferred payments and services. ➢ Review impact on capital programme ➢ Review changes to grant giving bodies' priorities	➢ Marketing of council owned commercial premises and re-purposing for alternative use ➢ Review interim COVID-19 payment processes to determine effectiveness	➢ Updated Treasury Management Strategy to reflect the revised lower interest rate environment and potentially more investment performance volatility.
Future resilience	➢ Collaboration with partnership organisations to review and support Communities to build resilience ➢ Support traders and local businesses to return ➢ Pathways for residents directly supported by Operation Shielding or the volunteering programme	➢ Engage with government guidance and statutory requirements. ➢ Review learning from new relationships with and offers of support from Bromley residents and organisations. ➢ Adopt a model that supports Green Recovery	➢ Service areas to develop Supply Chain provision in case of future emergency (Materials, PPE, Food, Technology). ➢ Maintaining an enhancing the Voluntary and Community Sector, including access to grant funding.

4. Planning for recovery: Vulnerable Residents

- 1500 residents are receiving support from the Council through a volunteering programme, - average satisfaction score for this support stands at 4.8 out of 5.
- Over 12,000 residents have been shielding with 1,700 receiving support from government in the form of a weekly food parcel or support with obtaining medicines.
- Of those shielded, requiring urgent support, 400 required some form of additional support from the council.
- Community Links Bromley (who run the matching and allocation of volunteers) have surveyed 400 of the 1000 mobilised volunteers, who have been pleased with the training and support they have received (4.5/5 score)
- Shielding residents requiring urgent support from the government will be written to by Bromley Council before the support from government ceases on 31st July, to signpost them to an assistance line for supermarket slots, volunteers or food bank referrals as appropriate.
- A newsletter has been distributed to all households to keep them informed of the council's COVID-19 response and to advise all residents of how to seek support and access a range of services
- Communication with volunteers to retain this additional capacity in the voluntary sector

4. Planning for recovery: Outbreak Control Programme

Providing a local authority response to contact tracing in Bromley. To include:

1. Managing complex outbreaks and situations
2. Supporting vulnerable individuals/households to self-isolate

Test and Trace

- Delivering a safe, effective and sustainable local arm of the national NHS Test and Trace programme for Bromley, that supports and coordinates with national and regional contact tracing efforts
- Direct local Covid testing

Outbreak Control

- Adapt national and regional guidance for local use – developing local Standard Operating Procedures (SOPs)
- Respond to incidents – declare incidents, outbreaks and convene incident management teams (IMT) as needed and identify IMT members for each outbreak scenario
- Enforcement – coordinate with the Health Protection Covid Board in taking control and enforcement measures as circumstances arise
- Reporting – record and report on incidents

Communications & Engagement

- Raise awareness & generate community understanding
- Targeted and bespoke local communications – via existing partnerships and channels, or via development of targeted, local guides and communications material for hard to reach groups
- Easy read versions of key literature

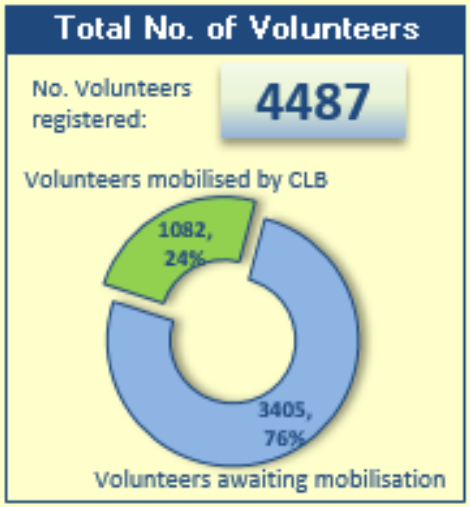
Data and Intelligence

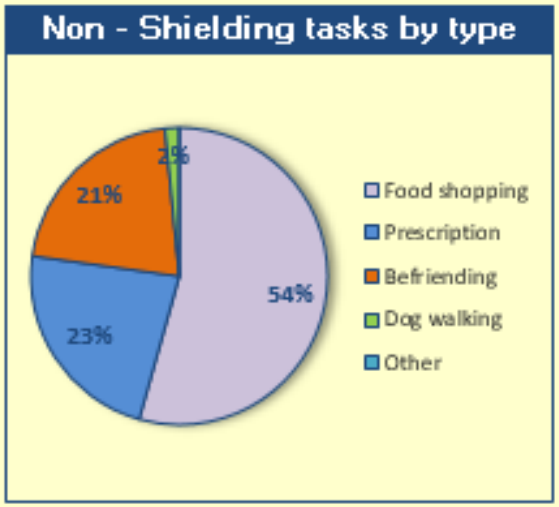
- Establishing a local data-hub to co-ordinate and communicate local information and data on tracing and testing in the local area
- Monitor local interventions and outbreak response (efficiency and gaps identified)
- To monitor impacts of COVID-19 on health, inequalities and the local economy (need for mitigation identified)

Care Homes/Extra Care Housing and Supported living

- Specific programmes targeting vulnerable residents

4. Planning for recovery: COVID-19 Shielding, Volunteering & Assistance





There are currently no formerly shielding residents that are receiving help directly from the Bromley Council food distribution hub at the Civic Centre.

The council's shielding food hub will be decommissioned during the last week of August with any remaining emergency food stocks being donated to the Trussell Trust foodbank located in the Civic Centre. All MyTime Active volunteers will end their volunteering work on the programme.

The resident outcomes project is underway with volunteers and clients being contacted to determine any ongoing support needs, in partnership with the Voluntary Sector. CLB will provide a bridging service from 1st September to continue to support volunteers and clients for up to three months as clients are matched with ongoing support services as necessary, or recorded as requiring no further support.

A small team of council staff (5 FTE) will remain seconded during September to support with resident outcomes, with the remainder of programme staff returning to BaU during the last week of August.

4. Planning for Recovery - Finance

Financial context – pre Covid

- Pre Covid ICS partners across the NHS and local authorities had been working to establish agreed financial plans for 2020/21.
- These plans included significant savings programmes for the year, including the assumed impact of our pathway transformation and productivity improvement programmes, required to support the delivery of 2020/21 budgets and financial targets.
- The plans also included a number of agreed investments, including targeted NHS investment in our out of hospital care system across primary care, community and mental health services, alongside investment in acute services to support underlying demand and improvements in access. For local authorities plans reflected the very significant pressure that social care and other budgets have been under for a number of years.
- Our plans included a continued commitment to pooled and delegated budgets across health and care to support integrated out of hospital service provision and to incentivise the development of integrated models of care, risk and gain share approaches.

Financial context – covid

- The pandemic resulted in significant changes to the funding and payments regime for months 1-4 of 2020/21. Block payments to cover core costs were implemented nationally, alongside mechanisms to recover additional covid related costs. As part of these new arrangements discharge costs were borne by the NHS on behalf of the system.
- Guidance is now expected for the rest of 2020/21 and as a system we will work to implement the national guidance with a key priority of providing financial certainty and stability across the system and to ensuring agreed system approaches to the management of risks or funding shortfalls. This will ensure that we are able to secure best value from available resource and support a funding approach that puts the needs and care of our residents at its centre.

2020/21 in year issues and implications

While the overall implications of the funding regime for 2020/21 are unclear at this point it is clear that we face a very challenging financial position across both the health and care sector:

- We have experienced an Increased year to date run rate associated with managing the pandemic – this means that in underlying terms we are spending more money than we expect to have available to us on a recurrent basis
- Our 2020/21 plans are on hold or delayed – resulting in efficiency programmes and the expected return on investment also being delayed during this year, meaning a bigger resulting financial challenge to address going forward
- Recovery will require investment in some areas and/or result in increased inefficiencies – to meet national/regional requirements (critical care, infection prevention and control), meet increased demand (mental health, waiting list backlogs) or to support on going delivery of benefits seen in the pandemic response (discharge, hubs for vulnerable people) – we will need to understand these requirements and reflect them in our financial plans

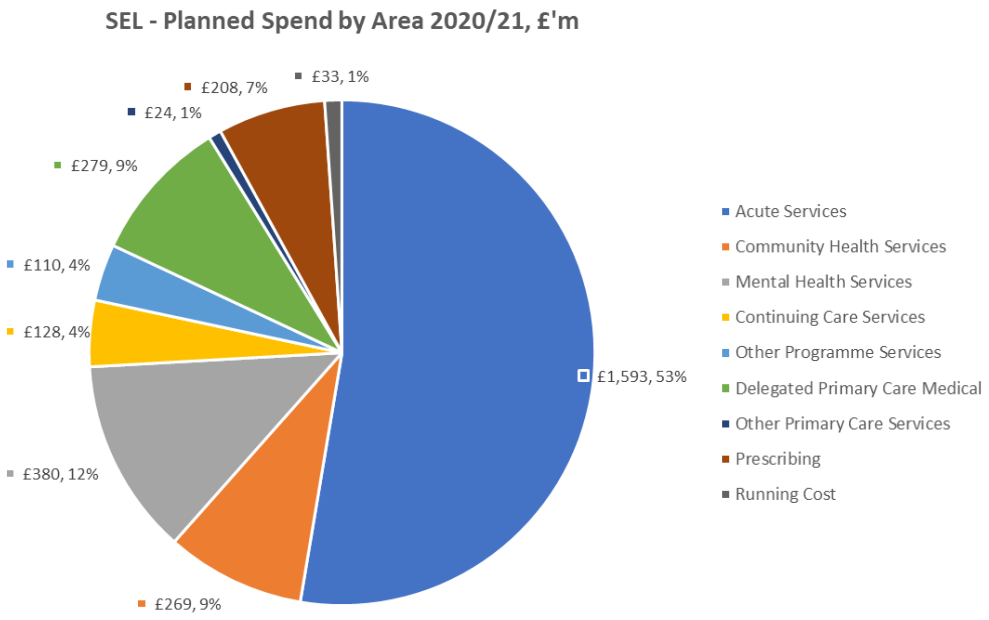
4. Planning for Recovery - Finance

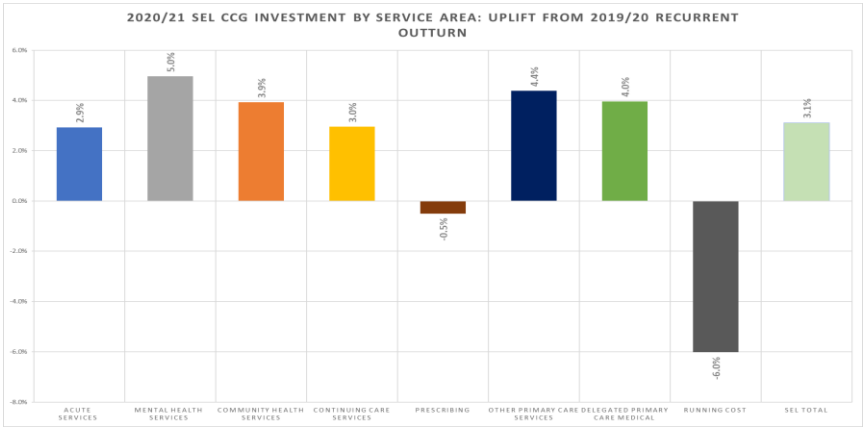
20/21 and 21/22 financial plans

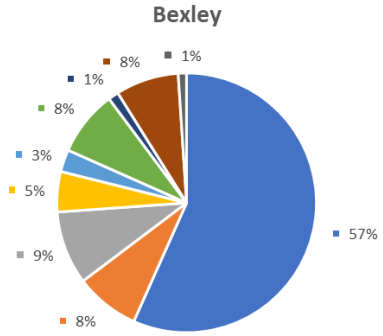
NHS – the chart below summarised the planned allocation of resource/investment by area related to CCG commissioned services, which reflected increased investment agreed across the system and which was aligned to the national Long Term Plan funding uplifts. The chart excludes non CCG sources of funding for SEL providers, noting these are significant for areas like specialised services.

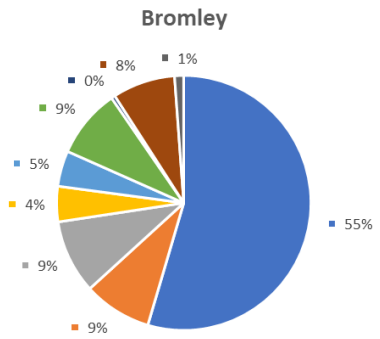
- The charts below are provided to illustrate our planned investment for 2020/21, to support expected demand and to support our service and investment priorities for the year.
- The Covid impact we have seen year to date, the financial implications of our recovery plans for the rest of the year plus the NHS/LAS funding regime for months 5-12 will result in a balance of spend/investment that differs to that planned
- It will however be important to understand these differences as we plan for the future and reassess out investment priorities whilst seeking to remain true to the overall objective set out in our Long Term Plan response of shifting investment to community based care and from treatment to prevention.

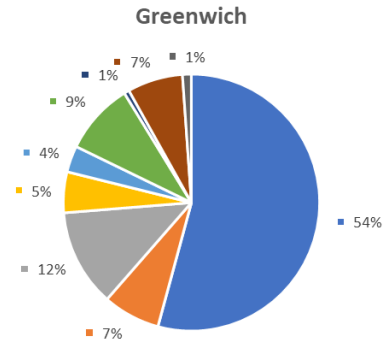
4. Planning for Recovery - Finance

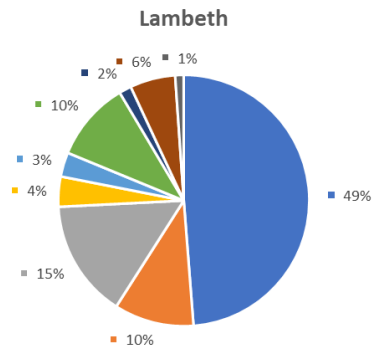


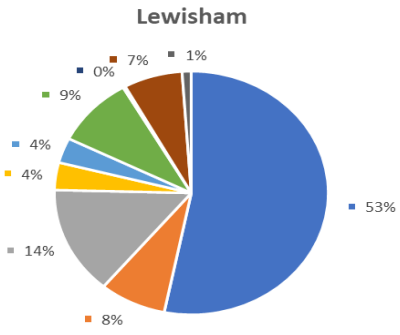


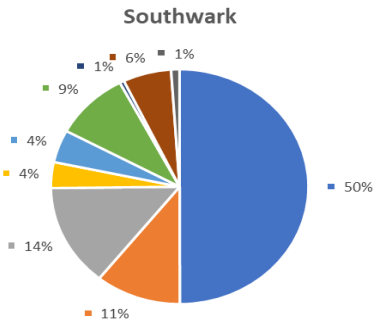












ONE BROMLEY

4. Planning for Recovery - Finance

Principles

Whilst recongising the financial uncertainty that we are currently operating under we are committed as a system to managing our financial challenges and future investments in line with the following principled approach:

- Commitment to our existing strategic investment plan – differentiated by area of investment to support agreed strategic priorities and the development of community based care.
- Recognition that we will need to transition back towards our existing strategic plan as in the short term (20/21 and 21/22) there will be additional recovery priorities that we will need to fund
- Commitment to work collaboratively and with collective responsibility across system partners to ensure that we make ends meet over this period
- Commitment to securing demonstrable best value and to maximising available efficiencies to secure the lowest possible run rate - at organisation and system level
- Commitment to ensuring that the recovery commitments we make are cost neutral overall e.g. they can be managed within the total resource available to the system, recognising that this may require stringent prioritisation
- Commitment to ensuring that there are no adverse consequences of our recovery (and wider) actions - where there is either an intended or unintended consequence by organisation we will collectively work to mitigate the risk for that organisation

Funding recovery

- We will need to review our recovery commitments for the reminder of 2020/21 in the context of the national funding approach and the above principles, with a focus on ensuring that we can fund prioritised recovery commitments whilst also seeking to reduce our run rate wherever possible.
- For 2021/22 we will need to adopt a systematic approach to our financial planning that also reflects our principles, takes due account of our pre Covid strategic investment plans and our identified recovery priorities. We are developing a planned approach for doing so and will develop this further over the coming weeks as national guidance and our own recovery implementation plans provide greater certainty in terms of the ask and available resources. Our work will include a collective review of:
    - The investments and savings that we had planned for 2020/21 - to determine those that remain important (strategically or as a vital component of our planned recovery) and those that we would deprioritise as not feasible/no longer a priority in the current circumstances - this will give us a *'carry forward' proposition* as a first step
    - Our original 2021/22 LTP commitments, our recovery commitments and requirements and the scope for new savings for 2021/22 - this will give us a *'new requirement' proposition* as a second step

4. Planning for Recovery - Finance

- An assessment of the carry forward and new funding requirements against available resource and in the context of our pre Covid investment strategy.
- The development of options for managing the expected gap between aspiration and available resource to support an agreed within borough and system wide prioritisation to enable us to set plans that match available resources.

Ensuring our financial planning and investment approaches support integrated delivery and optimised utilisation of available resource

- As a system we are clear that we need to move away from the pre Covid funding regime if we are to support our objectives of downstream strategic investment shifts, the development of our prevention and community based care offer, integrated service delivery underpinned by genuinely pooled budgets, system approaches to risk and gain share to incentivise innovation and financial sustainability plus collective responsibility for managing the system finances. This will include our Long Term plan commitment to move away from the Payment by Results funding model.
- There are a number of key pathways or service areas that we will need to work through to determine approaches that best meet these objectives.
    - Doing so will secure a system proof of concept in terms of demonstrating our principles and ensuring a collective agreement on the way forward for these areas that embed the benefits seen during the pandemic whilst also providing a sustainable funding approach for recovery/the future.
    - Potential areas that we will will consider are: discharge, Continuing Health Care, community services 2 hour rapid response/48 hour discharge models, shielding/vulnerable hubs, urgent and emergency new access models and digital by default. All will require agreed resourcing and resourcing shifts, alongside securing appropriate system incentives and risk/gain share approaches, to secure a sustainable financial delivery model.

Availability of capital funding to support recovery

A system capital allocation has been notified for business as usual capital plans in SEL.
In addition capital funds are anticipated, but not yet confirmed, to support A&E/SDEC and endoscopy and diagnostic work streams. SEL has submitted plans for these.
Capital bids have also been submitted for CCU expansion and surge capacity.
Nationally £600m has been announced, in addition to system capital allocations, to support critical infrastructure. This will be distributed across systems partly based on backlog values. This will be constrained where BAU plans exceed the notified system BAU capital allocation.

4. Planning for Recovery - Finance

Bromley Borough View

Key Local Issues / Challenges

There are a number of key local issues / challenges which need to be addressed as part of the local borough based recovery plan and these include;

- **Hospital Discharge Scheme** – this has been put in place in mid March to allow early facilitated discharge of residents and avoidance of admission to acute settings during the pandemic with no assessments being undertaken, both financial or CHC. Whilst the local authority has been involved in the process of finding placements for residents, this has been funded entirely by health via a reimbursement process. This arrangement is underpinned by the existing Section 75 agreement plus the addition of a new schedule which is in the process of being signed by both parties When this scheme ends, in terms of recovery, there will need to be an agreed plan across health and social care for assessing all clients within the required timeframe.
- **Growth Funding** – growth was initially expected to be circa 5.5% but in the revised allocation, this has been capped at 2%. Therefore, once any contract negotiations are recommenced, it will be essential that growth is only agreed at 2% maximum to ensure that the borough works within its financial envelope. Discussions and relationships will need to be well managed in order to achieve this.
- **Better Care Fund** – again growth was initially expected to be 5.5% but the revised allocation has capped growth at 2%. This has been communicated to Local Authorities for months 1-4 and the arrangements for month 5 onwards is awaited. However, this has impacted upon the system financial position, relationships with council colleagues and the ability to deliver services locally. This will need to be revisited as part of the recovery plan once the position for the remainder of the year is known.

4. Planning for Recovery - Finance

- **QIPP Delivery** – QIPP plans were put on hold due to the COVID pandemic but as we move into recovery, these will need to be reviewed to establish what is possible to put in place for the remainder of the year and how much could be delivered. For the borough specifically, the 2 main areas to be assessed are prescribing and CHC. The prescribing QIPP was circa £1.7m for the year, work will need to start to review this and see what is possible and all schemes will be reliant upon GPs working with the Medicines Management Team to deliver this. The top actions as part of recovery are;
    - Review original QIPP plan for 20-21 to identify which areas could be implemented first / most easily
    - Look to maximise income from rebates by reviewing rebates across all 6 boroughs and streamlining where possible
    - Review current prescribing practice to determine if there are any new areas where medicines QIPP savings could be identified

In terms of CHC QIPP, this is being taken forward at a SE London level by the Chief Nurse but with local teams responsible for delivery, the original value for the year was circa £950k. Again, a review will take place to assess the potential delivery in the remainder of the year and which schemes can be implemented. The top actions for recovery in this area are;

- Initially will need to consider how the caseload has changed since Covid (increase in deaths, CHC assessments paused etc.) and what impact this may have on CHC finances
- Review opportunities for a SEL shared resource for CHC reviews
- Increasing use of the care homes' AQP framework
- Extending collaborative commissioning of specialist nursing home care
- Collaborative commissioning of specialist domiciliary care (adults and children)
- Ensuring consistency in SEL choice and equity arrangements

It should be noted that given the implementation / mobilisation of any QIPP scheme, it is unlikely that any impact will be seen for CHC or prescribing until quarter 4 at the earliest.

- **Out of Hospital Schemes / Other Transformation Schemes** – One Bromley is working on a number of transformation projects. The challenge around delivery of any of these schemes will be the need to work as a system to deliver the changes without any additional finances i.e. resources will need to be recycled potentially across current organisational boundaries. This will require a true ICS approach to working.

4. Planning for Recovery - Finance

Local Finance Based Risks

There are a number of risks which need to be considered some at both SE London CCG level and at Bromley Borough level and some of which are more local, they have been set out below;

- Risk/uncertainty of not yet knowing what the financial regime for the remainder of the financial year will be;
- Risk of relationships being damaged by impact of financial regime on both the borough and its partners;
- Risk of QIPP schemes not being able to be mobilised as quickly as expected and so reduced impact in 2020/21;
- Risk of impact of localised new wave of COVID in Bromley Borough;
- Risk of recovery actions being impeded by lack of finance as an enabler;
- Risk of not being able to recruit into key posts within the borough structure and hence not deliver on the recovery actions due to financial restrictions being imposed;
- Risk of borough not being able to utilise the full powers under delegation due to the imposed financial regime, the lack of flexibility and decision making powers may hinder the local recovery work;
- Risk of impact of winter specifically in Bromley with its elderly population.

Local Financial Governance Arrangements

- NHS SE London CCG has a Schedule of Matters in place which sets out limits of delegation for staff, in addition there is a separate "emergency" Schedule of Matters in place for the approval of COVID-19 spend. As we move to recovery, it is expected that we would revert back to the main Schedule of Matters which is in line with the CCG constitution. The move to recovery will require strict adherence to financial governance issues in order to control spend in all areas.

Key Next Steps for Financial Recovery

- Support re-establishment of QIPP delivery locally;
- Support robust financial governance to control costs;
- Support out of hospital projects;
- Work to produce a FOT position for 20/21;
- Start to work up 21/22 budgets when planning guidance received;
- Support Hospital Discharge Scheme exit.

4. Planning for Recovery - Finance

Local Authority Position

MTFS and current budget monitoring position

Details of the Council's 'budget gap' considered as part of the 2020/21 Council tax report are shown below:

	2020/21	2021/22	2022/23	2023/24
	£m	£m	£m	£m
Budget Gap (2020/21 Council Tax Report), excluding mitigation and transformation savings	9.20	14.20	21.30	39.90
Mitigation savings	-5.10	-7.80	-13.40	-16.90
Transformation savings	-4.10	-5.60	-5.90	-6.10
Budget Gap (including mitigation and transformation savings)	**0.00**	**0.80**	**2.00**	**16.90**

The latest financial monitoring position for 2020/21 identifies a net overspend of £1.5m which excludes the impact of Covid-19. This represents the impact of the first two months of the financial year and the fully year impact of 2019/20 outturn. The most significant financial risk to the Council relates to Covid-19 impact.

Impact of Covid-19

To date the Council has received £74.8m of revenue funding for Covid-19 (excluding funding for Business Rate relief). Of this amount, £52.5m is for small and medium business grants, £5.7m ringfenced for other activities such as Infection Control and Test and Trace, and £16.6m is unringfenced.

The potential net cost of Covid-19 is currently estimated at £49.5m (costs of £19.9m and loss of income of £29.6m). £5.0m of this is covered by the ringfenced grants and hospital discharge funding, so there is an overall potential funding gap of £27.9m.

However, some of the potential financial impact on council tax and business rates will be shared with the GLA and any financial impact of reduced collection are accounted through the Council's Collection Fund which results in the revenue impact appearing in future years (2021/22 and beyond).

Although the ultimate net cost will change, as the impact of the 'transition' and 'new normal' will change costs, this illustrates that the potential costs remain only partly funded. Unless fully funded through Government grant then the only options available for the Council is to drawdown any monies available in the Central Contingency Sum, use of reserves or explore any possible mitigation

5. Link to wider system plans: NHS providers

The One Bromley Executive has managed the response to covid-19 locally using a collaborative approach. The One Bromley Local Care partnership includes:

- Community (Bromley Healthcare)
- Mental Health (Oxleas NHS FT)
- Acute (King's College Hospital NHS FT)
- Primary care (Bromley GP Alliance & PCNs)
- Voluntary sector (Bromley Third Sector Enterprise)
- Local hospice provider (St Christopher's)
- Local Authority (London Borough of Bromley)
- South East London CCG

Two One Bromley Recovery Plan workshop events were organised to consider what integrated services or new ways of working we wish to continue & develop.

Recovery plans from all One Bromley partner organisations were submitted to:

- Understand opportunities & impact across the system
- System wide assurance and review/ oversight on partner recovery plans
- Understand opportunities and the impact these will have on all parts of the system
- What the system can do to support partners in implementing the plans

6. Infrastructure: Whole system demand and capacity planning

Enabler

Description

- One Bromley seeks to create a demand and capacity model that fulfils the following 3 criteria:
  - Demand in the model is based on information provided from South East London / NHSE and others and then at what capacity is then needed to full fill this demand.
  - Looks at historic trends from Wave 1 Covid response and learns from it. i.e. how does prediction compare to actuals and how can we learn from this to inform wave 2
  - Becomes a scenario based model for the second wave.
- This will be achieved through resource, expertise and organisational sharing of data and working across One Bromley. Ultimately the model we produce will need to demonstrate sufficient capacity is in the system to meet demand and respond effectively to modelling scenarios from NHSE/I. The model will also inform decision making for capacity and commissioning for One Bromley.
- Production and ownership of the model will have an emphasis on cross organisational working.
- The One Bromley Model will seek also need to consider other developing and existing models such as the emerging Boston Consulting Group SEL Demand & Capacity model
- Beyond Covid response and planning, the One Bromley model will support our ongoing strategies and commissioning intentions.

Key Priorities

- Governance - It is proposed that the One Bromley Performance & Outcomes group is repurposed to drive the demand and capacity modelling forward. This will mean regular meetings and a reassessment of the key people from across the system who need to be in attendance.
- Capacity - One Bromley will require focused resource and expertise from across the system to be able to deliver this work. We will need an understanding of the key people across our system who could be identified to assist with this work, what their levels of capacity re and whether additional resource will need to be procured
- Data – An audit will need to be undertaken to ascertain available data required for the model and gaps in access

Key Risks

Key Risks	Mitigation
Capacity – Capacity across the system may not exist in sufficient quantities to drive project forward	Agreement from Exec to source and fund resource
Data sharing – IG implications may slow data sharing across the system. Need systems and processes also to house and work with data	IG expertise to facilitate data sharing. Investigation into warehousing solution
Expertise – Required expertise in modelling will not be availably within the system, or that if that expertise exists, sufficient capacity will stop them engaging in the project	Agreement from Exec to source external expertise if required

Milestones & Timescales

Milestones	Timescales
1. Group set up to take ownership of the development of a single One Bromley Demand & Capacity model	August 2020
2. Investigation into data availability and access	August2020
3. Agree and source resource and capacity for the work	August 2020
4. Commence work on first iteration	Early Q3
5. Resolution of any IG implications to sharing of new data feeds	2020/21

6. Infrastructure: Estates

Enabler

Description

- Delivery of transformational change through the development / implementation new models of care
- Delivery of high quality, accessible, integrated care closer to home
- Delivery of solutions to reduce improve quality and reduce variation
- A focus on prevention & long-term improvements in health and wellbeing
- Delivery of solutions to achieve long term financial sustainability across the borough

Key Priorities

- Development of a health and wellbeing centre in Bromley town centre using ETTF & Wave4 Capital money.
- Review and examine the current primary care estate priority issues within Penge & Anerley
- Increase Utilisation of the new Orpington Health and Wellbeing centre including the MRI Suite.
- Utilisation and rationalisation of Estate across the borough. Working with local Providers/ commissioners to find new ways of working together across Bromley and SEL including an updated mapping exercise of all local Estates.

Key Risks

Key Risks	Mitigation
1. Valuations for Bromley H&WBC site are not acceptable in terms of agreement with LA and/or represent VFM	Regular meetings with all parties involved
2. Impact of Covid-19 means increased interim void space at Orpington H&WBC	Work with Local Providers and NHSPS colleagues to ensure it is utilised
3. Finding an acceptable solution for GP Practices in Penge which is agreed by all parties	Working closely with practices to ensure we can meet needs of population.

Milestones & Timescales

Milestones	Timescales
1. Agree the Funding route for Bromley H&WBC.	July 2020
2. Submit the Bromley H&WBC Outline business Case	Sept 2020
3. Complete the feasibility study and confirm the options to support the Penge and Anerley GP practices.	July 2020
4. Arrange a Local Estates forum to restart the local mapping exercise	July 2020
5. Look at Borough and highlight sites for potential disposal and those where we can increase Utilisation	July 2020

6. Infrastructure: Digital

Enabler

Description

- Working across SEL to develop a current infrastructure and support service across the differing locations and stakeholders to ensure systems can be accessed and supported in a timely manner, meeting the hardware specifications of required systems and updated regularly.
- Working with the business intelligence work stream to develop the One Bromley strategy to align to the STP and One London direction of travel. Within the strategy, ensuring there is a timeline for accessing and bidding for funding where the opportunity presents.
- Allowing access as appropriate to health records for multiple organisations.
- The Covid pandemic has led to an acceleration in our digital response, which we will continue to build on with growth in primary Care and staff support
- We will seek to expand our digital initiatives to support wide array of pathways and other programmes such as primary Care
- The digital enabler programme will be built upon close collaboration across our One Bromley organisations to ensure timely and IG compliant sharing of data and where appropriate patient records.
- The Digital enabler will also support One Bromley's Population health Management ambitions

Key Priorities

- Access to health records - In developing One Bromley, we have the opportunity to set a precedent of viewing data from multiple organisations that until now has only been achieved across some partners for specific pieces of work.
- Implementation and roll out of Office 365 across SEL CCG staff
- Implementation and rolls out of Office 365 across all SEL GP Practices
- Stocktake across the boroughs to ensure the same quality IT service is being applied to all.
- Looking across the borough for joint working opportunities and economies of scale.

Key Risks

Key Risks	Mitigation
Uncertainty of funding due to the spend from COVID emergency implementation	Ensure all requirements are defined to the SEL team

Milestones & Timescales

Milestones	Timescales
1.Office 365 to corporate staff	Dec 2020
2.Office 365 to GP staff (phased to ensure all 365 features are implemented correctly	Nov 2020
3. Wifi update to GPs	Mar 2021
4. GP Spoke Server update	Mar 2022
5. Health Record- Joining with Social Care (LBB procuring presently)	Mar 2021

6. Infrastructure: Market Fragility & Development

Enabler

Description

- Ensure robust contractual process and governance for One Bromley (LCP) whereby commissioners and providers discuss, agree and implement how they can work together to oversee and manage improvements in services and health outcomes for local people within their collective budget.
- Ensure Providers are aware of their responsibility and remit within One Bromley and how it impacts the individual contracts held.
- Ensure One Bromley LCP is aligned within general direction and strategy of SEL ICS.

Key Priorities

- Review and identify most appropriate contractual approach for One Bromley LCP. (ICP Contract or Alliance)
- Update current Alliance Contract in terms of specification, governance and funding to ensure robust contractual management whilst longer-term contractual options are being reviewed.
- Review impact of LCP contract on Procurement regulations and Provider agreement to system working.
- Acknowledge impact of system wide issues (COVID etc..) on market and develop Market Position Statements that engender market development in the right (growth) areas in line with LCP.

Key Risks

Key Risks	Mitigation
Providers have different views on contract approach and may not reach a consensus on contract type.	Options will be taken to One Bromley Exec for agreement.
Providers unable to innovate to new system (LCP) working whilst maintaining contractual requirements on individual contracts and supporting System wide issues e.g. COVID.	Need to be clear between Providers and Commissioners when issues could arise and agree local variation.
NHS and Local authority Procurement rules do not align with LCP direction.	Review relevant guidance and any issued discussed at One Bromley Exec.

Milestones & Timescales

Milestones	Timescales
1. Agree Contract Variation for current Alliance Contract for 2020/21	Sept 2020
2. Agree contractual form for One Bromley (ICP or Alliance).	April 2021

ONE BROMLEY

6. Infrastructure: Workforce

Enabler

Description

- Support staff health and wellbeing and ensure safe working
- Agile working practices supported
- Joint leadership
- Implementation of business as usual workforce process including appraisals, mandatory training, sickness absence reduction and recruitment
- Joint One Bromley recruitment, retention and development projects- promoting diversity and inclusion
- Review availability and ongoing support needs of volunteers
- Support given to new ways of working to support new pathway development
- Risk assessment and support for particular at risk staff groups

Key Priorities

- Ensure wellbeing support continues to be available for all staff
- Ensure risk assessments including mental and physical checks are carried out as per national guidance
- Staff working from home to have Display Screen Equipment assessments to support agile working
- Supporting safe return of staff that are shielding
- Explore further joint professional & clinical and non clinical leadership & decision making
- Increase the number of student placements within and across providers including the student placement project across One Bromley
- Implement joint virtual careers fair
- Explore how to continue to engage volunteers
- Implement business as usual workforce processes including appraisal, mandatory training, sickness absence reduction and recruitment
- Support development of individuals and teams to work in new ways

Key Risks

Key Risks	Mitigation
Free national health and wellbeing resources not being available	Local wellbeing resources have been developed and will be shared and made available to as many staff possible within One Bromley
Schools not able to link with the virtual career fair being arranged	Discussions with schools as to what support they require, format they would prefer and timing occurring
Volunteer workforce available reduced	Consideration as to priority uses of volunteers and how they can be supported to continue

Milestones & Timescales

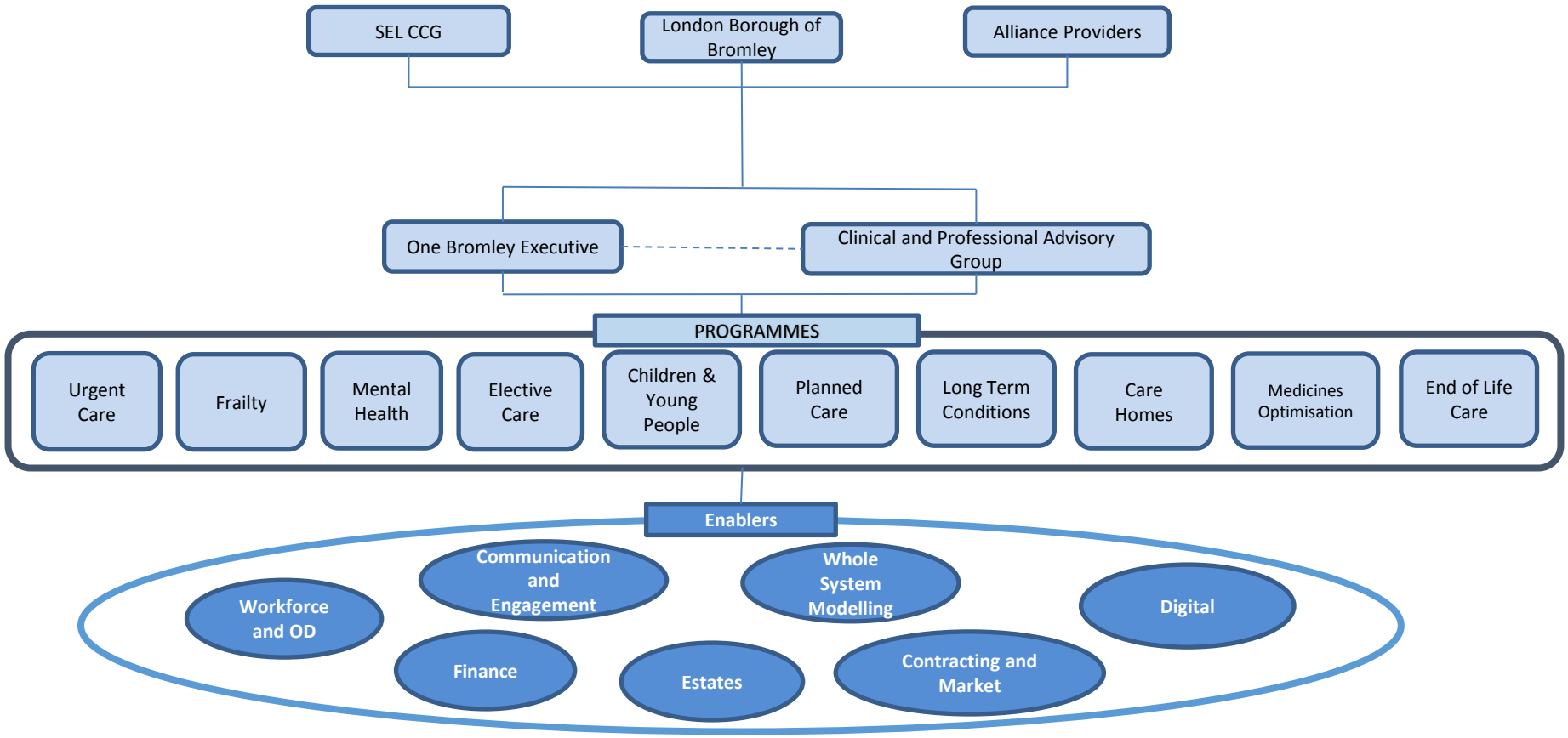
Milestones	Timescales
1. Review health and well being offer and possibilities sharing resources	August 2020
2. Carry out physical and mental risk and DSE assessments as per national guidelines	Ongoing
3. One Bromley leadership and governance processes explored and agreed	August 2020
4. Implementation of BAU workforce processes including appraisal, mandatory training, recruitment and sickness reduction	July 2020
5. Virtual recruitment fair implemented	Oct 2020
6. Review availability and ongoing support needs of volunteer workforce	Sept 2020
7. Increase student placements	Sept 2020
8. Development of staff to support new ways of working	ongoing

ONE BROMLEY

7. How will we deliver this: Leadership

- Develop the existing One Bromley Governance Arrangements to align with the new Borough Based Structures and the South East London Integrated Care System
- Recovery plan to set the priorities and programme for One Bromley over the next 18 months
- Delivery of the plan to reported to the One Bromley Programme Board and the Borough Based Board
- Communications and engagement plan for engagement with residents and patients is being developed

7. How will we deliver this: ONE Bromley Governance Structure



7. How will we deliver this: One Bromley Executive

Responsibilities:

- Implementation and delivery of the One Bromley plan as set out by the Programme Board
- Oversight and collective delivery of workstreams and enablers which require leadership and co-ordination at a local level
- Enhance partnership and integrated working across health & social care, promoting commitment to the Alliance principles and objectives
- Receive progress reports on One Bromley workstreams
- Managing key risks and issues escalated at ground level

Membership:

- Representatives from all member organisations from the Local Care Partnership
- Nominated executive, clinical and professional leads from each organisation

Board Arrangements:

- Meets on a fortnightly basis

Accountability:

- Single strengthened governance structure at a very senior level but the One Bromley Executive will report directly back to individual organisation which will remain sovereign. The Board will set the strategy and agree the delivery programme, holding the system to account for performance and delivery in assigned areas of responsibility.

7. How will we deliver this: One Bromley Clinical and Professional Advisory Group

Responsibilities:

- Provide the Programme Board with a care and clinical perspective on the development of their strategic plans and objectives;
- Advise the Programme Board and Executive on specific proposals to improve the integration of services across health and social care;
- Review and support the work of the Executive to ensure a co-ordinated approach on clinical matters among the different professions and within the component parts of the local health and care system;
- Take an active role in advising the ICS Board and Executive on the potential for service improvement;
- Engaging widely with local clinicians and other professionals, with a view to encouraging broader ownership of the work of the ICS;
- Provide an integrated local clinical and professional perspective on national policy issues.

Membership

- Clinical and Professional Representatives from across Bromley

Board Arrangements

- Chair to be determined
- Frequency to be decided, but may include some joint meetings with the One Bromley Executive

7. How will we deliver this: Engagement with our residents (1 of 4)

Bromley services are committed to delivering meaningful and integrated engagement with local people and communities and have a good track record in this area. It is critical that our Covid 19 recovery plans are informed by patient experiences and their views, and that we work with them to have services that meet the needs of Bromley residents.

Our recovery plan is informed by the following:

1. Engagement on our One Bromley integrated transformational programmes and plans

Over the last few years we have engaged with patients and local communities to inform our integrated care services either through capturing patient experiences or working directly with patient representatives to test and shape our improvement programmes. From this work we have had support and feedback on:

- Integrated proactive and person centred care pathways.
- Integrated care for frail patients.
- Virtual working in primary care services - through patient online, econsult and virtual appointments.
- Clinics provided through video conferencing in a school for young people with epilepsy
- Reviewing pathways for some outpatient services to reduce the need for face to face outpatient appointments.
- Patient involvement in the procurement process for a GP service for all care homes in Bromley.
- Development of primary care networks and new roles within primary care services – namely active sign posters and social prescribers.

Through our engagement, we know that:

- People with learning disabilities prefer to have face to face contact and many don't use a computer or the internet.
- Many of our older residents do not use the internet.
- Children and young people want more prevention and early intervention to support their emotional wellbeing.
- People with long term conditions want the right information and support to enable them to manage their condition and live as independently as possible.
- Patients do not want to repeat their history to different health professionals - they want their care to be more coordinated.

7. How will we deliver this: Engagement with our residents (2 of 4)

2. Capturing feedback from communities on their experiences of receiving care during the pandemic. This intelligence gathered by One Bromley partners will continue to inform Bromley recovery planning and includes:

- Surveys to vulnerable people who have received support from Bromley Council or the Government during the pandemic.
- Telephone and email surveys and aims to measure the effectiveness of the support they are receiving.
- Survey to capture feedback on using general practice services during the pandemic. This will also gather intelligence on whether people have avoided using these services and why.
- Telephone and online surveys to capture views on using hospital services, including those who were treated for Covid-19 and how safe people feel coming back into hospital.
- Evaluating the experience of those using the Bromley Covid Community Monitoring Service.
- Capturing views of those using community health services in a different way during the pandemic - including telephone consultations in community paediatrics.
- Monitoring of incidents, complaints and compliments regarding altered service provision.
- Feedback from young people on using CAMHS services in a different way.
- Weekly virtual community engagement events held by Healthwatch Bromley.
- Resident survey to gather experiences of using domiciliary care and other social care services.
- Surveying young people with special educational needs and disabilities (SEND) to gather their views on preparing to return to school.

Some of the feedback themes emerging from this work include:

Positive feedback:

- High satisfaction rates on the support provided by Bromley Council to vulnerable and shielding residents. This has included getting in essential supplies and help getting prescriptions.
- Appreciation of the NHS and services remaining open.
- Positive feedback about the video conferencing, phone and email consultations provided by GPs. However this does not work for everyone.

Communication/Information/Education:

- Support for all the precautionary measures put in place in hospitals and other face to face services but need to focus on improving signage, communication and public education - such as providing information in other languages, easy read and verbal reminders to sanitise and wash hands.
- Need to ensure patient information provided before face to face appointments will answer patient questions and include precautionary measures on the journey into hospital, and what to expect before, during and after face to face appointments.
- Be aware of people who are deaf and who therefore cannot lip read staff when they are wearing a mask.
- Improve communication and information when transferred from ICU to a general ward.
- Lack of information about recovery and isolating at home once discharged (for those who had Covid-19). More advice and links to community support would have helped.

7. How will we deliver this: Engagement with our residents (3 of 4)

Mental Health:

- Worries about financial hardships, obtaining food supplies, stress and anxiety etc.
- Increasing rates of mental health issues, anxiety, stress and worry caused by or exacerbated by the pandemic.
- Lack of access to digital technology is creating anxieties and feelings of isolation.
- Difficulty in accessing emotional support services.
- The impact of having had Covid-19 on mental health and how this can impact recovery.

Services coordination:

- Reduce the numbers of people in outpatient clinics, and support for telephone and video conferencing.
- The need to return to normal services.
- More patients used the emergency department as they could not see their GP face to face.
- Delays in receiving prescriptions.
- Separation of patients whilst in hospital to avoid asymptomatic patients being treated alongside more severe cases.

Other:

- People are seeking help from services late due to fears of contracting Covid-19.
- Difficulty in raising issues around domestic violence due to lack of privacy from abusers.
- Concern over lack of PPE available to health and social care providers.
- Improve cleaning and infection control within the hospital.

In addition to our local work, NHS England/Improvement is carrying out engagement work to understand experiences and is working with partner organisations such as National Voices, the Refugee Council, the University of Bradford, Groundswell and the NHS Youth Forum. Across London, Imperial Health Partners are in the process of carrying out a dialogue and deliberation exercise with a representative sample of Londoners to understand how those living and working in the capital feel about measures that have been put in place as part of the response to Covid-19 and to explore expectations as we plan recovery. This work will lead to a set of principles and expectations to inform recovery planning in August 2020.

7. How will we deliver this: Engagement with our residents (4 of 4)

HOW WILL WE FURTHER ENGAGE WITH RESIDENTS?

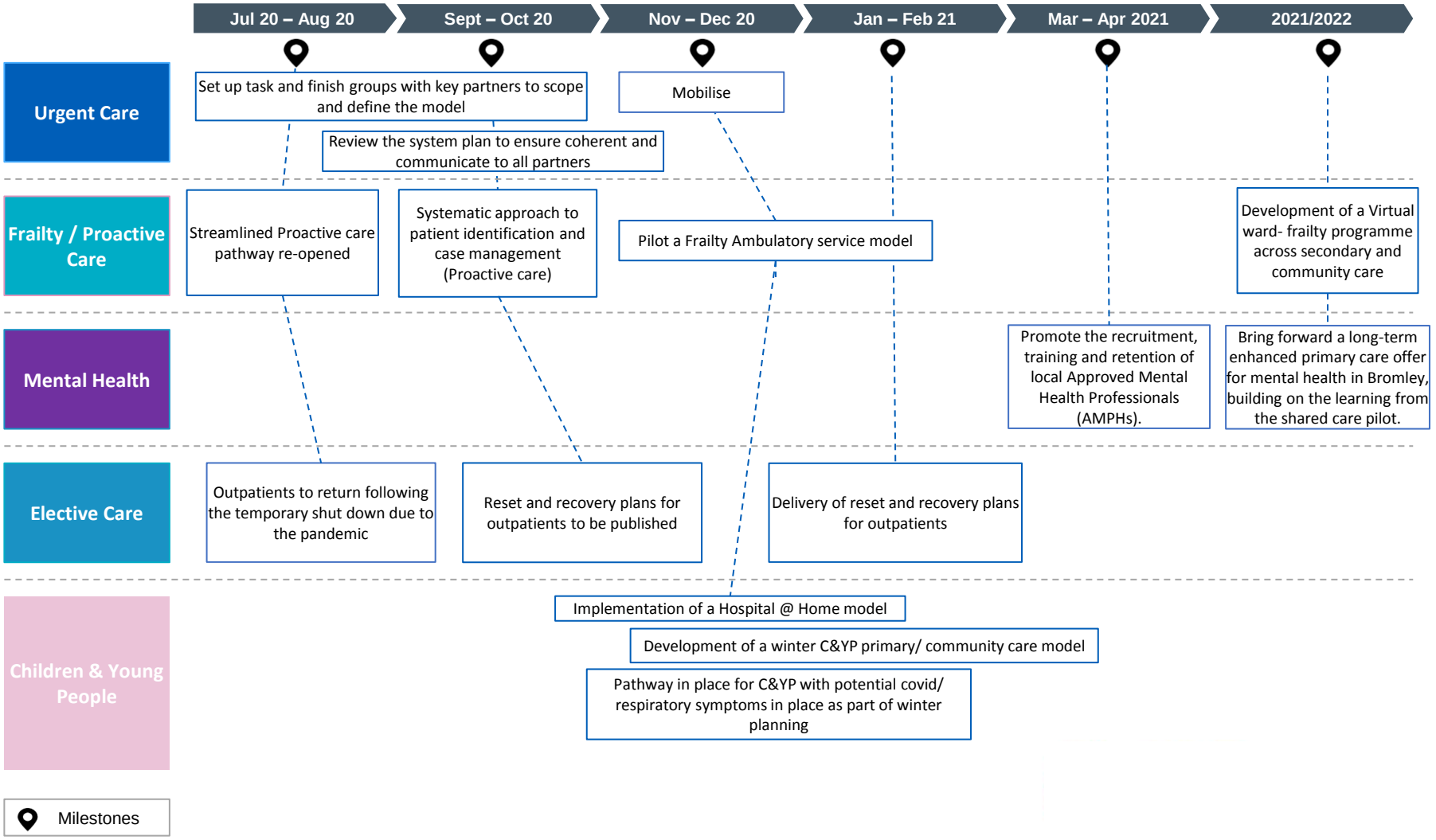
The One Bromley Communications and Engagement Forum will be responsible for working together to deliver the engagement needed to inform, test and shape our recovery planning. We are in a strong position in Bromley to do this as we have been working in an integrated way on communications and engagement for some time.
During July, August and early September, we will continue to collect feedback from our residents on their experiences of receiving care during the pandemic and their views on how we will provide services in the future. This feedback will continue to be fed into appropriate service areas and by the autumn a comprehensive record of all intelligence gathered will be brought together and shared across the Bromley system in order to inform further developments and improvements. This engagement work being undertaken by One Bromley partners, includes groups that are disproportionately impacted by Covid-19. It involves a range of methods of capturing feedback including surveys, telephone calls, on-line meetings etc.

In August we held a public event to provide an opportunity to explain our recovery plans to Bromley residents and to seek their feedback on a public summary of our recovery plan which will be published and distributed in September. The summary will explain how we have responded to Covid-19, what will be different for them and how they can help local services by accessing care at the right time and from the right place. It will also include some questions to enable us to continue to capture their views and experiences.

The One Bromley C&E Forum will work together to develop a comprehensive C&E Plan to oversee and manage engagement on our future plans and priorities. This will involve working with programme and commissioning leads to advise, support and deliver meaningful and proportionate engagement on the long term priorities set out in the recovery plan.

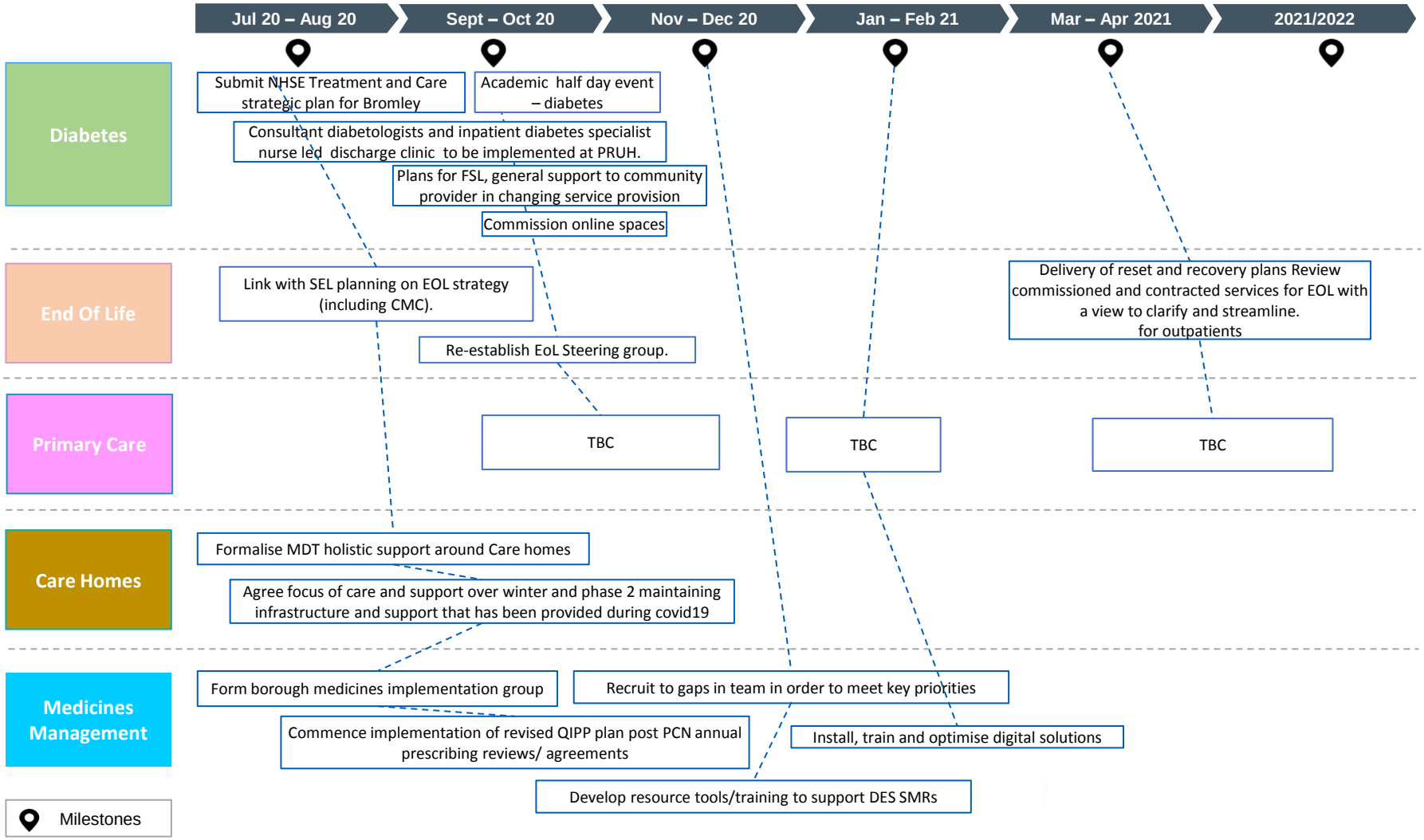
7. How will we deliver this: Milestones for delivery (Page 1 of 3)

Our action plan identifies key steps and milestones to enable us to achieve our objectives and outcomes



7. How will we deliver this: Milestones for delivery (Page 2 of 3)

Our action plan identifies key steps and milestones to enable us to achieve our objectives and outcomes



7. How will we deliver this: Milestones for delivery (Page 3 of 3)

Our action plan identifies key steps and milestones to enable us to achieve our objectives and outcomes