Bexley Wellbeing Partnership (1/6)

South East London Integrated Care System

Vision

Our vision is to improve the health and wellbeing of our population by creating a health and care system that is better for everyone. Transformation will be achieved through a partnership approach between the Bexley Wellbeing Partnership, local communities and the South East London Integrated Care System. We will become a vibrant and diverse network of organisations with individuals in each Local Care Network who are committed to improving health and care outcomes through integration, early intervention, streamlining access and supporting people to stay well for longer through the delivery of a *Neighbourhood Health Service*.

Deliverables / Improvements since 2023/24

- Implemented *Your Life, Your Choice Bexley* digital platform increasing availability of information on care, support and advice.
- *Trusted Partner* model of reablement has been mobilised and being embedded within each neighbourhood.
- Delivered of the *Reducing Health Inequalities Programme* in each of our 3 neighbourhoods.
- Focused effort on our neighbourhood model and the long- term delivery of a 'neighbourhood health service' within our established three Local Care Networks.
- Implemented two frailty *Virtual Ward* admission avoidance pathways with over 80% occupancy.
- Expansion of London Care Record access and embedding the Universal Care Plan (UCP) – Bexley now has the highest proportion of residents who have a UCP record.
- Delivered Year 1 of the *School Superzone* Project in areas of high deprivation and comparative obesity rates.
- We have incorporated the *Strengthening Families* Programme into our health visiting model.
- Adopted a population health management approach with development of the Frailty Joint Strategic Needs Assessment.
- Partnership consensus borough-wide focus Frailty and address and support those with multiple long-term conditions in our neighbourhoods.
- Emotional Literacy Support Assistant accessed by approximately 300 children during the past academic year.

Key Challenges / Opportunities Remaining

Challenges:

- The ability to fully integrate was compounded in 2024/25 by changes in staffing and complexities across programme areas
- Progress in commissioning and delivering within programmes has not been at the pace anticipated
- Data quality and consistency; variances in the capturing of accurate data impacts on our ability to join up information in a way that enables us to clearly monitor, measure and report on the impact and effectiveness of our interventions.
- Supporting staff to adopt and embrace change is resource intensive but crucial for future ways of working to bring about culture change

Opportunities:

- Build strong relationships across the partnership and develop these, alongside communication pathways and shared priorities, to improve our effectiveness and support us in creating scalable opportunities and practices
- Commitment to strengthening collaboration, coproduction and codesign through our voluntary sector and local communities
- Alignment of metrics and outcome measures to evidence effectiveness and assess impact of new models of care
- Reprioritise programmes of work for 2025/26 ensuring effort and energy is on delivering the most impactful initiatives

Bexley Wellbeing Partnership (2/6)

South East London Integrated Care System

	What are our priority areas for 2025/26	Why has this been identified as a priority areas?
1	**Children & Young People**: to keep children and young people physically and mentally well, supported by services close to home.	Supporting Children & Young People was identified as a priority by residents as part of our engagement in developing our Joint Health & Wellbeing Strategy. Focusing on early interventions will result in positive impacts on health and development by improving mental and physical well-being, build resilience, and reduce the risk of future challenges such as poor academic performance, unemployment, and chronic health issues.
2	**Mental Health**: to treat mental and physical health equally, promote good mental wellbeing and intervene early.	Bexley has a high prevalence of mental health challenges, with adults having relatively low self-reported wellbeing. Providing coordinated care, closer to home and prioritising mental health will help us to address long-standing disparities in care, and promote early intervention, to improve population wellbeing, living, quality of life and health and care outcomes.
3	**Healthy Weight**: to reduce levels of obesity by making obesity everybody's business.	This is a Joint Local Health & Wellbeing Strategy priority. Health and Wellbeing Strategy. Bexley has high levels of obesity, including higher rates of childhood obesity. Obesity carries an increased risk of certain cancers as well as the risk of developing chronic diseases. Our focus on addressing obesity will ensure the long-term viability of our health and care system by avoiding the increasing costs associated with obesity, improving resource allocation, and promoting a healthier population.
4	**Frailty**: to meet the needs of frail older people through effective, integrated community-based care.	This is a priority in the Joint Local Health & Wellbeing Strategy. Bexley has the second largest over 65 years population in South East London with frailty estimated to affect 27.4% of those aged 50+. National evidence indicates that frail people are more likely to experience adverse outcomes after a seemingly minor event. The early identification of frailty supports health and social care teams to take action to prevent poor outcomes after an intervention and to start a pathway of care to address the issues contributing to frailty.

Bexley Wellbeing Partnership (3/6)

South East London Integrated Care System

Priority Area:

Supporting **Children & Young People** *throughout life*

What are the actions we will deliver in 2025/26

Integrated Child Health Model:
- Adopt population health management methodology to understand demand
- Hold partner and wider stakeholder events to co-design an integrated model of care
- Trial and evaluate a new community based integrated child health model

THRIVE (Mental Health and Wellbeing):
- Deliver a cross-sector engagement event to raise awareness and ensure shared understanding of the THRIVE model
- Identify existing 'THRIVE' practices already in place, mapping them to the THRIVE Framework needs-based groupings
- Develop and implement plan for agreed priorities

Population Health and Inequalities Impact

Adopting a population health management approach in designing and delivering initiatives supports integrated teams to reduce health inequalities through offering targeted proactive, personalised and preventative healthcare for our communities. Target support, care, and services to those who need it or will benefit from it the most, enabling us to focus on preventing ill-health and make the biggest impact on improving outcomes

System Sustainability Impact

Based on outputs from existing Integrated Child Health Model, we would expect:
- Triaged patients to be provided with advice and guidance resulting in reduced waiting times
- Increase in community and neighbourhood-based care
- Reduction in hospital-based activity

Priority Area:

Supporting People with **Mental Health** challenges

What are the actions we will deliver in 2025/26

Continuation of the Bed Recovery Programme:
- Improve bed flow and improve length of stay
- Reducing ED presentations utilising alternative care pathways

Community Mental Health Transformation – Phase 2 implementation:
- Pilot new ways of working in the hub and primary care for enhanced integrated community provision to improve access and experience for those accessing mental health services
- Increase the number of physical health checks for people diagnosed with a severe mental illness

Population Health and Inequalities Impact

Improving mental health enhances population health and tackling health inequalities by addressing the close links between mental and physical health and wellbeing, particularly among vulnerable groups. Mental health issues are often closely linked with other social determinants of health and access to healthcare. Focus on mental health improvement to create a more equitable healthcare system ensuring everyone can lead a healthy life.

System Sustainability Impact

Creating a more accessible and flexible system by integrating services; the Mental Health Plan improves coordination and reduces fragmented services, optimising resources and enhances patient outcomes. Neighbourhood care with easier access supports sustainability through a reduction in demand for acute and emergency services. Early support enables a more cost-effective, efficient, and resilient healthcare system.

Bexley Wellbeing Partnership (4/6)

South East London Integrated Care System

Priority Area:

Supporting people to maintain a **Healthy Weight**

What are the actions we will deliver in 2025/26

Embedding Healthy Lifestyles:

- Support and assess delivery of Primary Care Tackling Obesity Plans
- Deliver healthy lifestyles activities in Bexley's *School Superzones*
- Commission services to meet Bexley's identified physical activity and mental health needs

Support for individuals:

- Roll out Tier 2 Weight Management service for school age children and widen referral sources. Deliver a *Cook & Eat* programme in North Bexley Neighbourhood
- Implement a tri-borough weight management service for adults with learning disabilities. Deliver an Oral health promotion service via health visiting, early years settings and care homes.

Population Health and Inequalities Impact

Addressing obesity ensures the long-term viability of our healthcare system by avoiding the increasing costs, improving resource allocation, and promoting healthier populations. Nationally, rates of obesity are expected to increase, and the impact of this on the health and social care needs of our community will be significant. Focussing on prevention and tackling overweight once it arises through increased uptake of healthy lifestyle resources and activities to prevent increasing obesity rates and associated rising costs in Bexley.

System Sustainability Impact

Commissioned services address health inequalities through ensuring service delivery within areas of higher deprivation and to communities with poorer health outcomes. Bexley's *Cook & Eat* programme will target those living in North Bexley where levels of obesity and poverty are higher. The prevalence of obesity within adults with learning disabilities are known to be higher than in the general population; a weight management service target this group with tailored provision to meet their needs will be commissioned

Priority Area:

Supporting older people living with **Frailty**

What are the actions we will deliver in 2025/26

Develop and implement Bexley's Integrated Neighbourhood Team model, delivering a *Neighbourhood Health Service* focusing on long-term conditions and implementing a borough-wide best practice all age Frailty model:

- Adopt population health management methodology to understand demand
- Complete asset mapping exercise
- Hold partner, wider stakeholder events to co-design an integrated model of care and develop an action plan for Age Friendly Communities
- Trial and evaluate new models of care through established integrated neighbourhood teams

Population Health and Inequalities Impact

Adopting a population health management approach in designing and delivering initiatives addresses the wider determinants of health. Reducing health inequalities through a targeted, proactive, personalised and preventative healthcare. A population health approach – targets support, care, and services based on who needs it or will benefit from it the most, enabling us to address variation and focus on preventing health deterioration to make the biggest impact on improving health outcomes.

System Sustainability Impact

Applying best practice models and current guidance, we would expect:

- Reduction in emergency department contacts within our over 65 age group
- Reduction in non-elective admissions to hospital for people with frailty and falls
- Reduction in number of primary care appointments following local community-based intervention
- Reducing associated health and social care costs

Bexley Wellbeing Partnership (5/6)

Priority Area	What are the outcomes we are aiming to achieve?	How are we measuring our impact?
Children & Young People	• Improved mental health, wellbeing and resilience of children and young people • Enhanced collaboration for integrated, seamless family-centred support delivered closer to home	• Reduction in hospital-based activity • Reduction in waiting times • DIALOG scores
Mental Health	• More people with acute mental health needs will receive timely, personalised care in the right place, delivered closer to home. • Residents with mental health needs and their carers receive timely, responsive and easily accessible support to live well and actively participate in their community for as long as possible.	• Reduction in hospital-based activity • Delivery of the 28-day community mental health waiting time standard • DIALOG score for patient outcomes
Healthy Weight	• Our primary care workforce will be equipped to contribute to the obesity agenda and support a healthy lifestyle through good livelihoods. • We will embed healthy lifestyles across the agenda via communicating core and targeted lifestyle messages. • More people will be provided with quality services that support weight management.	• Number of resident participation and engagement in healthy initiatives • Proportion of residents who make positive changes following completion of a programme and the % who have sustained those positive changes at 6 and 12 months • Delivery against Primary Care Obesity Plans
Older People & Frailty	• Improve the health and well-being of our population affected by frailty and long-term conditions and enable more people to live well at home as they age where this is safe and the right choice for them • Increase early intervention and prevention so that people are admitted to hospital only when necessary and are safely discharged in a timely manner.	• Embed recording of Clinical Frailty Score in all settings • Appropriate admissions and Emergency Departments attendances • Delaying admissions to long-term care

Bexley Wellbeing Partnership (6/6)

South East London Integrated Care System

What do we need from enablers and partners to deliver?

- **System-Wide Commitment** to collectively work towards integrated, cross-sector integration and commit to collective action for shared success.
- **Embedding Collaborative Culture** by fostering strong, adaptable partnerships, sharing resources, learning from past experiences, and embracing innovative practices.
- **Workforce Development** recognising our most valuable asset are our staff; support workforce training, retention, and ensuring capacity and alignment with shared objectives.
- **Data and Digital Infrastructure** to enable secure data-sharing, population/predictive modelling and systems to enhance decision-making and coordination through linked data.
- **Funding and Resource Alignment** to ensure sustainable investment and equitable sharing of resources to drive system-wide initiatives.
- **Proactive and Personalised Approaches** that emphasise early intervention and approaches tailored to individual and community needs.
- **Creative Approach to Estates Challenges** to mitigate where some GP practices are delivering services from poor quality buildings and are at risk of losing their site(s) as well as address dispersed services, access issues and increases in residential new builds.

How will we work in collaboration with our system?

- **Integrated Partnerships**: Leverage established forums and groups to unify our efforts around shared goals.
- **Engagement with Primary Care**: Fully integrate primary care into system-wide pathways and services to provide a *neighbourhood health service*.
- **Capacity and Relationship Building**: Create space and opportunities to foster deeper relationships, align priorities, and share information and knowledge across the system.
- **Inclusive Governance**: Actively participate in system meetings and boards to ensure cohesive decision-making and accountability.
- **Commitment to Co-design**: We will actively involve our 17 partner organisations, key stakeholders, our local voluntary sector, residents and Community Champions in designing and delivering integrated solutions.

How will we engage with our population?

- **Tailored Engagement**: Collaborate with specific client groups, carers, and partnership networks to co-design and shape services that meet diverse community needs.
- **Feedback and Transparency**: Actively seek input on services through surveys, satisfaction measures, and existing feedback mechanisms such as "Ask Bexley" to continuously refine collaboration and improve experience.
- **Community Connections**: Engage in community events and leverage established networks, for example Local Care Networks and Healthwatch, to strengthen ties with residents.
- **Community Champions and Stakeholders**: Partner with community leaders, Patient Participation Groups (PPGs), and stakeholders to amplify outreach and representation.
- **Diverse Engagement Routes**: Utilise a variety of communication channels, including the 'BWP Comms & Engagement Forum' and partner-driven engagement routes, to ensure inclusivity.

How will we monitor and share progress?

We will monitor progress through:

- Tracking against our success metrics and outcome measures
- Regular review via our existing Programme Board/Partnership meetings
- Embedding robust governance processes and frameworks, including oversight via an established Bexley Community Based Care Delivery Board

We will share progress by:

- Completing quarterly highlight reports for review and oversight via our existing Programme Boards/Partnerships
- Providing quarterly/6-monthly updates on progress, flagging risks, issues and barriers as well as lessons learnt to the Bexley Wellbeing Partnership Committee and the Bexley Health & Wellbeing Board
- Utilising agreed communication channels to ensure alignment and visibility