Integrated Forward Plan

Bexley Wellbeing Partnership

Bexley Wellbeing
Partnership

bexleywellbeing.org

Contents

Bexley is a place where...

“We have a tradition of working together for a better future”

We have come a long way together.

Our partnerships, relationships and collective ambition have helped support Bexley residents through difficult times.

In October 2023 a new Joint Local Health and Wellbeing Strategy was adopted by Bexley’s Health and Wellbeing Board and set four key priorities determined by local need: Children and Young People, Ageing Well, Obesity, and Mental Health. This plan sets out how we will achieve our strategic priorities together.

The COVID-19 pandemic was a difficult period for all communities. However, it also spurned new ways of working between health, social care, the voluntary, community and social enterprise sector, and numerous community members in Bexley.

The pandemic also shone a harsh spotlight on the importance of addressing health and care inequalities to ensure we are resilient as individuals, families and communities.

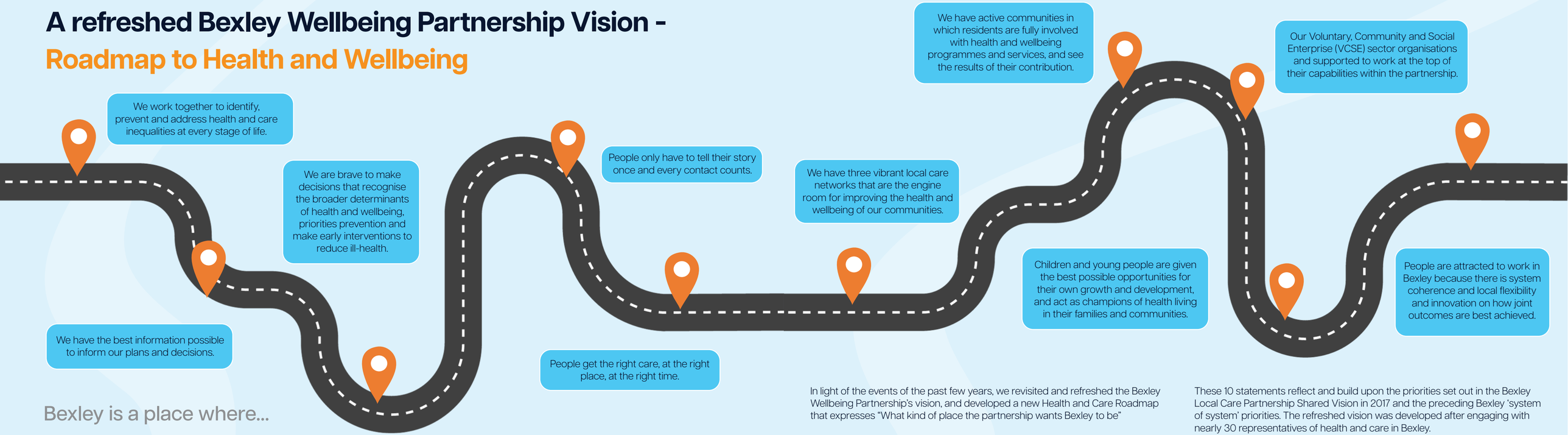
As the Bexley community we are not immune to global shocks and nationwide challenges. The continued higher cost-of-living is putting strain on individuals, families and communities, with knock-on effects for the health and wellbeing of all residents.

Our response to these challenges has been to build on the work that led to the formation of the Bexley Wellbeing Partnership in 2017, and the desire to continue the momentum and learning from our recent experiences.

This is set out in our Integrated Forward Plan.

A refreshed Bexley Wellbeing Partnership Vision -

Roadmap to Health and Wellbeing



Bexley is a place where...

In light of the events of the past few years, we revisited and refreshed the Bexley Wellbeing Partnership's vision, and developed a new Health and Care Roadmap that expresses "What kind of place the partnership wants Bexley to be"

These 10 statements reflect and build upon the priorities set out in the Bexley Local Care Partnership Shared Vision in 2017 and the preceding Bexley 'system of system' priorities. The refreshed vision was developed after engaging with nearly 30 representatives of health and care in Bexley.

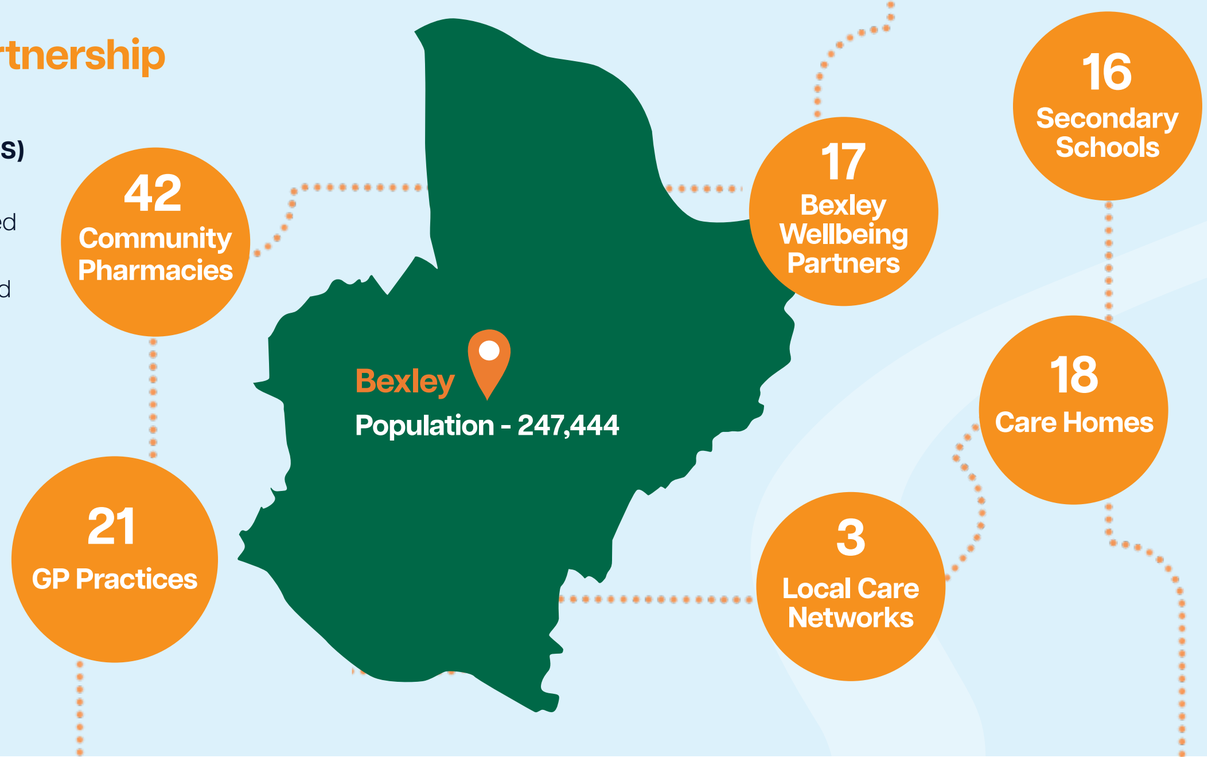
Our Place, Our People, Our Partnership

South East London Integrated Care System (SEL ICS)

In 2022, Bexley became one of six South East London Boroughs that came together to form a single Integrated Care System. The ICS brings together all the public organisations responsible for publicly funded health and care in South East London.

An increasingly diverse population

- 24% of the total population are of Black, Asian & Minority Ethnic heritage which is expected to become more diverse rising to 30% by 2045
- The proportion of adults identifying as Lesbian Gay, Bisexual, Transgender Queer, Intersex, and Asexual +/other in England is between 2.5% and 5.9%. LGBTQIA+ people over 25 in Bexley would



A growing and ageing population

- Children and young people under 25 account for almost a third of the population, whilst older people aged 65 and over account for a sixth.
- Bexley's birth rate is higher than the England average. Projections show the population will grow by 10% to around 275,000 in 2023. By 2050, >65s will make up almost 1/5 of the population. The largest increase will be in North Bexley.

Inequality affects many of Bexley's residents

- Despite its relative affluence, one in seven people live within the 30% most deprived areas nationally.
- North Bexley is the most deprived area in our Borough, with significantly higher levels of poverty disproportionately affecting Children and Young People and seniors.
- Life expectancy between the least and most deprived areas is 6 years. In Bexley, excess winter deaths in those over 85 are 30.4% compared with 21.9% in London and

Together we identified Health and Wellbeing Priorities along four points in residents life journeys, reflecting the biggest populations health and well being needs.

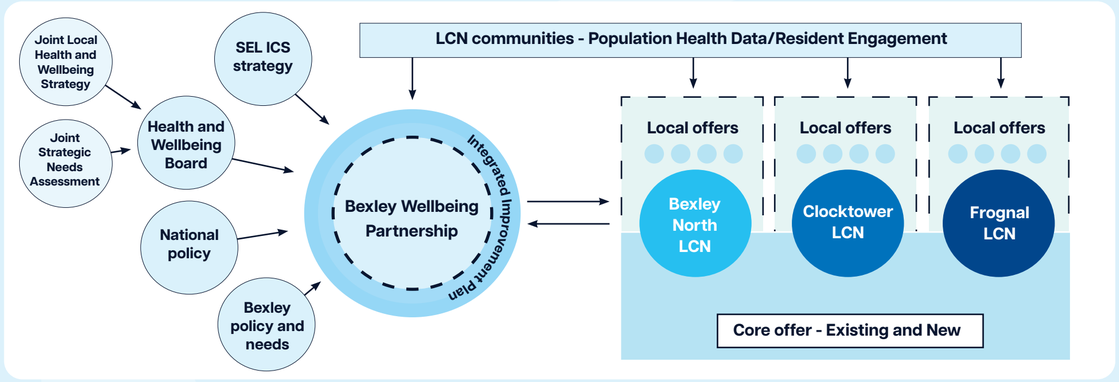
Improvements in these areas can be achieved through a partnership approach between the Bexley Wellbeing Partnership, the communities we work with and the South East London Integrated Care System (SEL ICS)

When designing our approach to supporting people at these life stages the common themes from our joint experienced were:

- Personalisation and promoting independence
- Focussing on prevention through a proactive approach
- Taking a strengths based approach, drawing on individuals resourcefulness and community assets
- Supporting carers and taking a 'think family' approach
- Creating a core and local model of delivery to tailor services around natural communities

Bexley has Three Local Care Networks that can draw upon the knowledge and insights of local teams and service users to understand and address local needs.

Local Care Networks (LCN) are themselves a hyper-local partnership of primary, community, social, mental health and acute care, working with the Voluntary, Community and Social Enterprise (VCSE) and their communities.



LCNs are themselves a hyper-local partnership of primary, community, social, mental health and acute care, working with the VCSE and their communities. They will be responsible for delivering many of the 'Core' elements of our Integrated Forward Plan and interpreting other elements of Plan to make them more accessible to and effective for their local populations. LCNs will also provide and develop a range of other services based upon local needs, including addressing health and care inequalities and access to primary care.

Our joint action plan explained...

Children and Young People: Supporting Children and Young People Throughout Life

To keep children and young people physically and mentally well, supported by services close to home. **Our plans for 2022 to 2025 cover:**

- Start well
- School years
- Addressing inequalities

The outcomes we will achieve are:

- Multi-agency working will increase to support key initiatives
- An improvement in infant and maternal health, including better support and clearer pathways for infant feeding with support and evidence on options, and an Increase in healthy birth weights
- An improvement in perinatal mental health
- More support for children in school years
- Creating an open and welcoming environment for all children through the use of peer support groups and improved access to emotional wellbeing

Mental Health: Supporting People Living with Mental Health Challenges

To treat mental and physical health equally, promote good mental wellbeing and intervene early

The outcomes we will achieve are:

- More people with acute mental health needs will receive personalised care in the right place and the right time closer to home
- Residents with mental health needs and their carers are supported to live well and work in the community for as long as possible
- Community mental health services will be embedded in LCNs
- More people living with dementia and their carers feel well and in control of their lives and dementia and people will have easier access to dementia support
- A reduction in the number of suicides and increased support for those affected by suicide

Our plans for 2022 to 2025 cover:

- Living well with dementia
- Personalised care closer to home
- Mental health and Local Care Networks
- Support for those at risk of suicide
- Living well and working in the community

Obesity: Supporting People to Maintain a Healthy Weight

To reduce levels of obesity by making obesity everybody's business.
Our plans for 2022 to 2025 cover:

- The food and physical activity environment
- Embedding healthy lifestyles
- Support for individuals

The outcomes we will achieve are:

- More people are able to access healthier, sustainable and affordable foods and live in an environment that inspires physical activity
- Our workforce will be equipped to contribute to the obesity agenda and support a healthy lifestyle through good livelihoods
- We will embed health lifestyles across the agenda via communicating core and targeted lifestyle messages
- More people will be provided quality services that support weight management, recognising the links between obesity and mental health and support these residents

Ageing well: Supporting Older People Living with Frailty

To meet the needs of frail elderly people through effective, integrated community-based care.

The outcomes we will achieve are:

- More people are able to live well at home as they age where this is safe and the right choice for them, with an expansion of housing options
- Older people are admitted to hospital only when necessary and are safely discharged in a timely manner
- More people can die with dignity at home or in the community with high quality, well co-ordinated support, with family and wider networks being support during a person's illness and after their death
- We will have assessed the roll out, quantity and quality of Advance Care Plans and their use

Our plans for 2022 to 2025 cover:

- Living well at home and reducing falls
- Living well in a care home
- Carer wellbeing
- Service development
- Dying with dignity at home
- Appropriate use of acute hospital provisions

To deliver against this plan the Bexley Wellbeing Partnership needs to provide enablers that cut across all four of the life-stage plans.

Asset mapping and development	• Bexley resource map • Supporting the development of the Voluntary Community Social Enterprise (VCSE) sector • Identifying opportunities for estates in the NHS and social care to be developed
Governance, accountability and alignment	• Workstream Memorandum of Understanding (MOU), leaders. Statement of mutual accountability. Reporting and escalation process • Identifying statutory and VCSE funding cycles and serviced can better aligned for • Awareness and alignment with emerging national and ICS strategies
Local Care Network	• Establish integrated LCN 3-year strategy, outcomes framework and operating plans • OD directed towards engagement and alignment of LCNs • Develop user journeys/pathways
Community engagement	• Develop a central resource for community engagement • Resources to support community activation • Stock of case studies, professional and user experiences/insights
IT and business intelligence	• Collate/develop outcome and progress measures, guided by evidence and best practice • Framework and strategy to map digital needs to deliver integrated plan including interoperability • Develop performance dashboards
Primary Care	• Improve access to core primary care services and same day integrated urgent care • Develop the mechanisms to support greater integration to enable community-based care • Enable core primary care services to focus on early identification and prevention
Organisational and workforce development	• Within Bexley Wellbeing Partnership to deliver joint strategic plans • Map and deliver specific training needs e.g. Trauma Based Approach, Difficult Conversation • Identifying and sharing best practice

A refreshed Bexley Wellbeing Partnership Vision

We revisited our partnerships vision in light of our recent and current challenges, asking what kind of place Bexley should be:

- We work together to identify, prevent and address health and care inequalities at every stage of life
- We have the best information possible to inform our plans and decisions
- We are brave to make decisions that recognise the broader determinants of health and wellbeing, prioritise prevention and make early interventions to reduce ill-health
- People get the right care, at the right place, at the right time
- People only have to tell their story once and every contact counts

Bexley is a place where...

- We have three vibrant, dynamic integrated local care networks that are the engine room for improving the health and wellbeing of our communities
- We have active communities in which residents are fully involved with health and wellbeing programmes and services, and see the results of their contribution
- Children and young people are given the best possible opportunities for their own growth and development, and act as champions of healthy living in their families and communities
- Our Voluntary, Community and Social Enterprise (VCSE) sector organisations are supported to work at the top of their capabilities within the partnership
- People are attracted to work in Bexley because there is system coherence and local flexibility and innovation on how joint outcomes are best achieved

Bexley Integrated Forward Plan - Children and Young People

Workstreams

2023	2024	2025+
Start Well		
Embed Maternity Voices Partnership	Implement findings from Maternity Partnership Work	Implement solutions to low birth weight
Improve infant feeding pathways and support for Bexley parents	Focus on infant feeding and creating a breastfeeding friendly environment	Continue incredible years pre-school until April 2029
Monitor maternity trust DNA rates and low birth weights	Model solutions to low birth weight based on data.	
Incredible years pre-school for parents and carers of children	Expand incredible years pre-school	
School readiness programme for children with social/emotional difficulties	Support development of perinatal mental health service	
Big school bears project to support transition into reception classes		
Developing a strategic multi-agency approach to Early Help		
Improving child protection with a focus on under-1's and domestic abuse		
Big school bears project to support transition into reception classes		
Increase training available to staff on trauma		
Improve health information and advice available to young parents		
Re-commissioning of the Bexley 0-19 service		
School Years		
Expand pre and post diagnostic support for CYP with autism		
Targeted support for Emotionally Based School Avoidance		
Pilot integrated primary care and paediatric model	Roll out integrated primary care and paediatric model	
Development of a single point of access for CAMHS		
Eating disorder prevention		
Incredible years school age basic parenting programme	Continued roll out of incredible years school age programme	
Local authority emotional literacy support assistant (ELSA)	Local authority emotional literacy support assistant (ELSA)	
Local authority resilience programme in primary and secondary schools	Local authority resilience programme in primary/secondary schools	

Workstreams

2023	2024	2025+
School Years		
Local authority early intervention speech and language programme	Local authority early intervention speech and language programme	
Recommissioning of the Bexley 0-19 Public Health Service		
	Review transition pathways and thresholds for services for ASD	
	Focus on Asthma diagnostics and management pathways	
	Stronger focus on substance misuse and addiction	
	Improve diagnostic and support pathways for ADHD	
Addressing Inequalities		
Focus on local commissioning and support for CLA		
Raising the profile of CYP needs at LCN level		
Sickle cell - articulate the gap in services		
Support health interface/commissioning into Bexley special schools		
Empowering Parents Empowering Communities (EPEC)	Continue EPEC expansion – increase parent group leaders	
Peer support group - fathers of black/Mixed heritage CYP with CSD		
Improve access to emotional wellbeing for LGBTQ+ CYP	Work to establish patient engagement networks for LGBTQ+ CYP	
Start mapping the needs of young carers		
Establish working group to review care leavers' transition pathways		
Increase update of immunisations and target specific populations		

Workstream	2023/24	2024/25	2025+	Outcome	Success measures
Start Well	Embed Maternity Voices Partnership to identify improvements to maternity care and continue projects through stop smoking in pregnancy steering group.	Implement findings from Maternity Partnership Work.		Increased multi-agency working to support key initiatives. Improved infant and maternal health.	Regular patient engagement feedback Reduced smoking rates in pregnancy. More women maintaining a healthy weight during and after pregnancy.
	Improve infant feeding pathways and support for Bexley parents.	Focus on infant feeding and creating a breastfeeding friendly environment.		More support and clear pathways for infant feeding with support and evidence on options.	Increased health and healthy infant weight, improved experiences for mothers, access to evidenced-based information.
	Monitor maternity trust DNA rates and low birth weights to identify if specific communities are more likely to be impacted.			More preventative approaches to infant weight starting in pre-conception and throughout pregnancy and post-birth.	Increased healthy birth weights.
	Implement the safety valve programme: Incredible years pre-school for parents and carers of children with concerns about behaviour of children aged between 3-6- School readiness programme for children with social and emotional difficulties, their parents/ carers, and early years setting staff- Big school bears project to support transition into reception classes.	Expand incredible years pre-school.	Continue incredible years pre-school until April 2029.	Improved parental confidence in managing behavioural needs in children reduced parental use of negative discipline reduced child conduct issues at school and home Improved parent/child relationships. Reduced need for SEMH assistance. CYP are coping with transition and settled in school.	Reported confidence increase by parents. Reduction in behavioural incidents in school. Reduced need for SEMH support. CYP have present with increased capacity to cope and self-regulate in school. Reception staff are more confident to support the needs of CYP, less need for reduced timetables/ or less delay in engaging with school.
	Developing a strategic multi-agency approach to Early Help in Bexley.				
	Improving child protection with a focus on under-1's and domestic abuse.				Reduced rates of domestic abuse in children.
	Increase training available to staff on trauma informed practice across the borough.				
			Explore ways to improve health information and advice available to young parents who are current or former looked after children through the antenatal period.		
		Support development of perinatal mental health services.		Improved perinatal mental health Increased access to perinatal mental health services.	Monitoring demonstrated improved wellbeing for service users.

Bexley Wellbeing Partnership
Bexley Integrated Forward Plan - Children and Young People

Workstream

School Years

2023/24	2024/25	2025+	Outcome	Success measures
	Development of a single point of access for CAMHS.	Subject to funding, implementation of a single point of access for CAMHS.	Streamlining access to CAMHS services for children and young people.	
Eating disorder prevention (train the trainer model).	Further implementation of eating disorder prevention.	Monitor and evaluate eating disorder prevention.	Slowing the velocity of the increase in eating disorders.	
Implement safety valve school years programmes, including: Incredible years school age basic parenting programme. Resilience programme in primary and secondary schools to improve social and emotional wellbeing, resilience, self-esteem, and confidence. Early intervention speech and language programmes in primary school.	Continued roll out of Safety Valve programmes.		Improved by parents confidence in managing behavioural needs in children reduced parental use of negative discipline reduced child conduct issues at school and home Improved parent/child relationships. Improved levels of resilience in CYP. Enable CYP to move from having moderate to mild levels of speech and language need.	Reported confidence increase by parents. Reduction in behavioural incidents in school. Reduced need for SEMH support. Improved reported social and emotional wellbeing, resilience, self-esteem, and confidence. Less likely to need an EHCP and needs are met at the mild to moderate level. Improved speech and language.
Local authority emotional literacy support assistant (ELSA).	Local authority emotional literacy support assistant (ELSA).		Better quality and increased number of friendships and relationships family members, peers, teaching staff.	Improved reported social and emotional wellbeing, resilience, self-esteem, and confidence.
	Ensure transition pathways for autism are reflected in the joint autism strategy, which is currently in development.		Improved transition pathways and stronger multi-agency working to support transition.	CYP with autism feel supported through transition and are more able to thrive in adulthood.
	Implementation of children's diagnostics and clinical management pathways for Asthma using Asthma nursing.		Reduction in A&E attendances for Asthma.	Improved asthma diagnostics and clinical management of asthma.

Bexley Wellbeing Partnership
Bexley Integrated Forward Plan - Children and Young People

Workstream	2023/24	2024/25	2025+	Outcome	Success measures
Addressing Inequalities	Sickle cell - articulate the gap in services and work towards increasing access.	Subject to funding increase capacity of community Sickle cell service.		Commissioning of services meets population demand.	Improved health and better clinical management for CYP with sickle cell anaemia.
	Ensure that there is a robust process for early identification and planning for the health needs of CYP with SEND in newly commissioned or expanded special educational provisions.	Review forward plan for health commissioning to special educational needs provision based on population needs analysis.		Commissioning of services meets population need.	Health needs of CYP with SEND are met within a school setting.
	Empowering Parents Empowering Communities (EPEC) for parents of children with SEND –increase the amount of parent group leaders and deliver more parental support to the local community and expand geographic reach.	Continue EPEC expansion – increase parent group leaders and monitor data outputs.		Parents report increased confidence in parenting techniques and increased social connection and support.	Increased number of parent group leaders, with a larger geographical reach.
	Peer support group for fathers of black/Mixed Heritage CYP with a diagnosis of autism.			Black and mixed-heritage fathers of CYP with autism can access peer support.	Improved confidence and social connection between black and mixed-heritage fathers of CYP with autism.
	Improve access to emotional wellbeing and peer-support for Lesbian, gay, bisexual, transgender, queer or questioning and others young people (LGBTQ+).	Work to establish patient engagement and peer support networks for LGBTQ+ CYP- based on their feedback.		Increased resilience, confidence, and access to social connection and community for LGBTQ+ CYP.	More LGBTQ+ children access emotional support and report improved wellbeing.
	Start mapping the needs of young carers and other vulnerable demographics through the school health education survey (SHEU).	Implement the SHUE survey.		Improved understanding of the needs of young carers in the borough in order to provide tailored support.	Better understanding of need and more intelligent commissioning for vulnerable young people across the borough.
		Establish working group to review pathways for 16-25 transition for care leavers.	Social care.	Care leavers are more prepared for adulthood and have access to appropriate support and service provision.	Care leavers report improved access to support and increased resilience in adulthood.
	Increase immunisations and target populations less likely to be vaccinated.			C&YP are immunised against preventable diseases.	Uptake of immunisations increases across all populations. Improved understanding among the population of vaccinations and their benefits .

Bexley Wellbeing Partnership
Bexley Integrated Forward Plan - Children and Young People

Bexley Integrated Forward Plan - Mental Health

Workstreams

2023	2024	2025+
Personalised care closer to home for people with acute mental health needs		
Ensure people with SMIs receive annual physical health checks	Ensure people with SMI have personalised care planning	
Ensure discharge residents are supported to access housing solutions	Continue to improve crisis support services in the community	Continue with ongoing plans to ensure the supply of housing solutions
Develop the offer of personal health budgets	Improve crisis pathways including community out of hours crisis services	
Living well and working in the community		
Improve access to mental health support in the community	Carers/families of people with MH needs are properly supported	Improve employment options for people with MH issues
Understand if there is an over representation in accessing acute MH services	Support a sustainable secondary care model to meet and manage MH needs	
Develop systems to screen residents using psychological community assets	Explore improvements tenancy support for people with MH problems	
Mental health and Local Care Networks		
Identify the footprint and location for MH specialist services	Expand neighbourhood hubs to include MH services	
Ensure MH and wellbeing are being reflected in LCN plans and priorities	Effectively publicise the range of community assets available	
Support a sustainable and resourceful VCSE sector		Embed a sustainable and resourceful VCSE sector to support MH needs
Living well with dementia		
Evaluate the dementia care home support multi-disciplinary team	Refresh the dementia action plan and enhance post-diagnostic support	Identify local priorities in the National Dementia Strategy
Implement the Dementia Connect Carer Support plan	Provide early support for people living with dementia	
Support for those at risk of suicide		
Improve awareness of Bexley's suicide profile	Create a better understanding of the help with is available to residents	
Make the best use of community assets to help reduce risk	Improve data collection and intelligence on cases and population risks	
Ensure partners across the borough feel skilled to have conversations about suicide		
Tackle health inequalities by focussing on prevention		
Support those affected by suicide through timely bereavement support		

Workstream	2023/24	2024/25	2025+	Outcome	Success measures
1. Personalised care closer to home for people with acute mental health needs	To ensure people with severe mental illness receive their annual physical health check. This will include working with all system partners to drive improvement and engagement.	Ensure people with severe mental illness have personalised care planning and there is communication with their families/carers to improve their physical health and normalise their life expectancy.		Residents with acute mental health needs will receive personalised care in the right place and the right time closer to home.	Reduction in waiting times to receive appropriate mental health support in a timely manner. Fewer people attending A&E or being admitted to hospital in a crisis. Reduction in referrals into secondary mental health services.
	Ensure residents who are clinically ready for discharge are supported to access appropriate housing solutions and community rehabilitation through the mental health rehabilitation relocation (capital) project and gathering feedback from them about their needs and experiences, and enabling peer support.	Continue to improve crisis support services in the community and reduce unnecessary attendances to A&E. Agreement to be reached regarding implementation of Right Care , Right Person as impact of change of policy becomes clear.	Continue with ongoing plans to ensure the supply of housing solutions and community rehabilitation in line with the borough's mental health needs trajectory.	People with severe mental illness will have personalised care planning to improve their physical health and normalise their life expectancy Carers/families of people with acute mental health needs feel engaged and involved.	Achieve SMIAHC national standard of 70% (September 2024).
	To develop the offer of personalised health budgets and direct payments to people with the mental health needs.	Improve crisis pathways including community out of hours crisis services, and hospital and crisis care placements including effective data sharing about individuals and feedback from service users on their needs and experiences.			
2. Living well and working in the community	Improve access to mental health support in the community , including commencing reprocurement of Talking Therapy services and Recovery and Employment services.	Carers/families of people with mental health needs are properly communicated with and have good access to support in the community, including to address their physical and mental health needs.	Continue to improve employment options for people with mental health issues.	Residents with mental health needs and their carers are supported to live well and work in the community for as long as possible Residents who are clinically ready for discharge will be supported to appropriate housing solutions and community rehabilitation.	Reduction in escalation of mental health problems because of unaddressed issues such as debt, housing, unemployment, drugs, alcohol and social isolation. More people supported within primary care. Increased access to Talking Therapies and early intervention services.
	Undertake local research to better understand whether there is an over representation in accessing acute mental health services against other boroughs in SE London.	Support a sustainable secondary care model to meet and manage mental health needs through the community mental health service's transformation agenda (this action is to be considered and developed further).			Increase in housing options for people with mental health problems.
	Develop systems to screen residents using a psychological community assets approach.	Explore opportunities to improve tenancy support for people with common mental health conditions .			
3. Mental health and Local Care Networks	Identify the appropriate footprint and location for different mental health specialist services at a borough-wide level and how they connect or work through LCNs adopting a Core and Local model of care).	Explore the expansion of neighbourhood hubs to include mental health services and encourage wider use of direct access services, enable access timely personalised support to prevent a crisis and reduce mental health inequalities.		Community mental health services are embedded in Local Care Networks, and providers work in partnership to intervene early and prevent escalation.	Expanded neighbourhood hubs to respond to mental health crises.
	Ensure mental health and wellbeing are clearly reflected in the priorities and plans of LCNs including addressing mental health inequalities and a voice for people with mental health needs.	Effectively publicise the range of community assets available in the borough and in LCNs that can support people with mental health needs.			Plans and priorities of the LCNS will include mental health and wellbeing, including the voices of people with MH needs Increase in the see of community assets.
	Support a sustainable and resourceful VCSE sector to support people with mental health needs and reduce mental health inequalities across the borough, including at LCN level.		To have embedded a sustainable and resourceful VSCE sector to support people with mental health needs and reduce mental health inequalities across the borough, including at LCN level.		

Bexley Wellbeing Partnership

Bexley Integrated Forward Plan - Mental Health

Workstream	2023/24	2024/25	2025+	Outcome	Success measures
4. Living well with dementia	Evaluate dementia care home support multi-disciplinary team and develop business case for continuation subject to outcome.	Refresh the dementia diagnostic action plan and enhance post-diagnostic support to ensure these services are equally accessible to all communities through improved collaboration between a wide range of clinical and non-clinical services including Dementia Connect and a focus on improving memory service waiting times.	Identify local priorities in the National Dementia Strategy (publication date TBC.	People living with dementia and their carers feel well and in control of their lives Dementia and diagnosis support is equally accessible to all our communities.	An increase in accessibility to dementia diagnosis.
	Implement the Dementia Connect Carer Support plan.	Provide early support for people living with dementia including teaching strategies to live with cognitive impairment, developing habitual patterns of behaviour for support through the life course, carers support and use of technology.			An increase in the number of people with dementia who have access to early support and teaching strategies.
	Improve awareness of Bexley's suicide profile and the steps we are taking to prevent suicides.	Create a better understanding of the help which is available to residents and those working and visiting Bexley.		Reduce the number of suicides and increase support for those affected by suicide.	A reduction in the number of suicides.
5. Support for those at risk of suicide	Make the best use of community assets with closely aligned borough strategies and programmes of work to help reduce risk.				An increase in the identification of those at risk of suicide.
	Ensure partners across the borough feel skilled to have conversations about suicide and are able to support those at risk.				Partners across the borough will be trained to have conversations around suicide.
		Improve data collection and intelligence by working with health partners, the coroner's office, local safeguarding boards and Thrive, London's Real Time Surveillance System (RTSS) to gain a better understanding of cases and population risks.			
	Tackle health inequalities by focussing on prevention and those most at risk of mental ill health, suicide and self harm.				

Bexley Wellbeing Partnership

Bexley Integrated Forward Plan - Mental Health

Bexley Integrated Forward Plan - Obesity

Workstreams

2023	2024	2025+
The food & physical activity environment		
Establish the Good Food network in Bexley	Explore opportunities around Healthy Streets development	Develop a wider food action plan for Bexley
Complete Health Impact Assessments on hot-food takeaway developments	Implement the Football Foundation Playzone programme	
Develop Craydene Green space in Slade Green		
Work with partners to deliver School Superzone in areas of high deprivation	Evaluate and learn from School Superzone approach	
Embedding healthy lifestyles		
Provide training to primary care staff on obesity	Up skill community health champions	Explore opportunities for local employers to support a healthier workplace
Support for individuals		
Engage with General Practice on GP Premium obesity plans	Supporting GP practices to deliver targets related to obesity	Support GP practices to implement their obesity action plans
Commission new tier 2 weight management service	Integrate weight management offer within the 0-19s Public Health Service	
Deliver HENRY programme from Children's Centres		
Update and communicate weight management pathways		

Bexley Wellbeing Partnership

Workstream	2023/24	2024/25	2025+	Outcome	Success measures
1. The food and physical activity environment	Establish the Good Food network in Bexley – (bringing together the voluntary and community sector), local authority, and other partners who work to alleviate food poverty.	Explore opportunities around Healthy Streets development, including encouraging active travel.	Develop a wider food action plan / strategy for Bexley.	Increasing the availability of healthier, sustainable and affordable foods.	
	Complete Health Impact Assessments on major new developments and development proposals that contain hot-food takeaways (new project).			Increasing the availability of healthier, sustainable and affordable foods.	
	Develop Craydene Green space in Slade Green, install new outdoor gym equipment and activate with the community.	Implement the Football Foundation Playzone programme and activate the spaces with the community.		Creating an environment that inspires physical activity.	
2. Embedding healthy lifestyles	Work with partners to deliver School Superzone in areas of high deprivation and with high comparative obesity rates, aiming to reduce inequalities.	Evaluate and learn from School Superzone approach and consider how to sustain the project.			
	Provide training to primary care staff on obesity (including raising the issue of weight) and signposting to relevant support.	Up-skill community health champions to signpost residents into appropriate areas of support.	Explore opportunities for local employers to support a healthier workplace.	Equip the workforce to contribute to the obesity agenda.	
		Develop a segmented communications and training plan on healthy lifestyles with communities and other stakeholders.		Support a healthy lifestyle through good livelihoods.	
		Using school health profiles consider what additional support can be provided to schools with high rates of obesity.		Embed healthy lifestyles across the agenda.	
3. Support for individuals	Engage with GP practices in regards to their plans for the GP Premium regarding obesity.	Supporting GP practices to deliver against the targets relating to obesity within the GP Premium.	Support GP practices to focus on implementing their action plans regarding obesity.	Communicate core and targeted lifestyle messages.	
		Focused work with the Local Care Network (LCN) with the highest rate of obesity, aiming to reduce inequalities.			
	Commission new tier 2 weight management service(/s) to support Bexley adults who are living with obesity, with a focus on reducing health inequalities.	Integrated weight management offer within the new 0-19s Public Health Service, supporting families and primary school age children.		Provide quality services that support weight management.	
	Deliver HENRY programme from Children's Centres and other community settings for families of children aged under five years old.			Recognise the links between obesity and mental health.	

Bexley Wellbeing Partnership

Bexley Integrated Forward Plan - Obesity

Bexley Integrated Forward Plan - Older People living with Frailty

Workstreams

2023	2024	2025+
Living well at home and reducing falls		
Promote pharmacy first service to older people	Develop statutory non-statutory Information sources	Reduce loneliness with targeted communications campaign
Develop community-based approaches to falls awareness	Stimulate the market to create residential care alternatives	Develop an integrated approach to technology-enabled care
Establish better understanding and insight about falls	Develop a falls awareness and prevention toolkit	
Review and develop community falls response model	Stimulate the market for day opportunities	
Living well in a care home		
Commission a joint care home framework	Review the enhanced health in care homes framework	Ensure residents have protection from eviction
Ensure consistency and equity in GP primary care		
Carer wellbeing		
Ensure the Carer's Action Plan is regularly refreshed	Raise awareness of carers assessments among health providers	
	Co-produce pro-active support for carers/families of frail people	
Appropriate use of acute hospital provision		
Monitor Home First impact on hospital attendances	Evaluate learning from the good hospital support pilot project	System-wide implementation of risk stratification tools
Review system impact of Home First approach to hospital discharge	Review system impact of Home First approach to hospital discharge	
Roll out the Virtual Frailty Ward model	Create a common process for sharing information about patients	
Enhance the scope of the 2 hour Urgent Care Response	Deliver new Trusted Partner model of reablement	
Dying with dignity at home		
Roll out virtual ward for end of life care	Ensure residents can make informed choices about end of life care	Review progress on delivering palliative end of life care priorities
Develop an action plan to implement the SEL Palliative and End of Life Care	Implement SEL PEOLC action plan	Assess advance care plans and their use
Service development		
Undertake district nursing review	Standardise and improve primary care identification of frailty	Create system dashboards for monitoring / improving service q
Ensure frail people are not excluded from digital access	Ensure data sharing between service that support frail older people	
Improve resident and relative voice		
Develop a market sustainability plan for home care/care homes		

Workstream	2023/24	2024/25	2025+	Outcome	Success measures
1. Living well at home and reducing falls	Promote pharmacy first service to older people through a targeted communications campaign.	Develop statutory and non-statutory sources of information so that people can more easily access care, support, and advice including self-help, peer support and actively contributing to their communities, reducing social isolation and increasing choice and control for residents.	Deliver targeted communications campaigns which promote opportunities to reduce social isolation and loneliness. Support people through life-changing events, promote wellbeing and inclusive, resilient communities.	More people able to live well at home as they age where this is safe and the right choice for them. An expansion of housing options to choose from for people with frailty. To be able to identify the link between falls and other factors.	Increased use of pharmacy first service. Decrease the number of frail older people who suffer from a fall, immobility, delirium or incontinence.
	Develop community-based approaches to falls awareness and prevention in Local Care Networks based around strength-building, co-ordination and public education.	Stimulate the market to create alternatives to residential care for older people (for example “extra care housing”).			Increase in the number of alternatives to residential care homes for older people.
	Establish quality information (data, case studies, user lived experience and professional insight) to gain better understanding and insights about the prevalence, nature, cause, and impact of falls; and identify the links between falls, immobility, delirium, and incontinence to inform decision making about all of these conditions.	In collaboration with relevant stakeholders (staff, residents and carers) develop a falls awareness and prevention toolkit with associated training and clinics for teams to be used in care homes and by unpaid carers.			Increase in staff trained with the falls awareness and prevention toolkit in care homes.
	Review and develop community falls response model including rapid response service (NHSE directive).	Stimulate the market for day opportunities in order to increase choice for residents and carers.	Develop an integrated approach to technology-enabled care.		Increase the number of day opportunities.
2. Living well in a care home	Commission a joint care home framework to support market development including innovation in dementia and digital transformation.	Review the enhanced health in care homes framework to identify areas for improvement (e.g. MDT working, medicines management).	Ensure that commissioning arrangements give greater protection to residents from eviction.	More people living well and independently in care homes.	Increase the number of people living well and independently in care homes.
	Ensure consistency and equity in GP primary care support for care homes (using new DES funding) including insights from user feedback and adopting a personalised approach.				A reduction in the number of residents being evicted.
3. Carer wellbeing	Ensure that the vital role of unpaid carers is recognised by ensuring the Carer’s Action Plan is regularly refreshed in line with changing carers needs as identified through quarterly Carers’ Partnership meetings.	Raise awareness among health providers of carers assessments to ensure equity of access.		Carers/families of frail older people have good access to support in the community, including to address their physical and mental health needs.	Have a refreshed carer’s action plan, in line with the quarterly Carer’s Partnership meetings.
		Co-produce pro-active support for carers/families of frail people through the Carers Partnership.			

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Bexley Integrated Forward Plan - Older People Living with Frailty

	2023/24	2024/25	2025+	Outcome	Success measures
4. Appropriate use of acute hospital provision	Establish key metrics/baseline data for hospital attendances and admissions impacted by Home First approaches and monitor them.	Evaluate the learning from the pilot project for support of good hospital discharge for people living with dementia and their carers currently running at QEH, with a view to future Home First planning.	System-wide implementation of risk stratification tools and Comprehensive Geriatric Assessment to identify and assess those most at risk of hospital admission.	Older people are admitted to hospital only when necessary and are safely discharged in a timely manner. Have a holistic view of hospital attendances and admissions impacted by Home First approaches.	A reduction in acute hospital admissions for ambulatory sensitive conditions.
	Review system impact of Home First approach to hospital discharge with the findings used to inform its future design and operation. This will include insights from patients and carers about what a good hospital discharge pathway looks like.	Map end-to-end care pathways (including dementia) to create seamless services for frail and older people.			Care pathways for frail and older people.
	Roll out the Virtual Frailty Ward model (including rapid response services and treatment in care homes) in line with agreed bed capacity and deliver on national occupancy trajectories.	Create a common process for sharing information about patients between community, primary care and secondary care (particularly in-patient teams) in a timely manner.			Virtual Frailty Ward 'up and working'.
	Enhance the scope of the 2 hour Urgent Care Response.	Deliver new Trusted Partner model of reablement.			Have delivered new Trusted Partner model of reablement services using ASCOF measures.
		Increase recording, use and access by families and all professionals of Advance Care Plans, which make individuals wishes clear and help to avoid inappropriate admission at end of life . This includes rolling out having "difficult conversations" training.			
5. Dying with dignity at home	Roll out virtual ward for end of life care in line with agreed bed capacity and deliver on national occupancy trajectories.	Ensure residents are supported to make informed choices about their end of life care and are able to plan ahead including timely development of an advance care plan.	Review progress on delivering palliative end of life care priorities.	More people can die with dignity at home or in the community with multidisciplinary support Family and wider networks are supported, both during a person's illness and after their death.	Increase of people trained in having "difficult conversations"Increased number people able to die with dignity at home.
	Develop an action plan to implement the SEL Palliative and End of Life Care (PEOLC) priorities for improvement in proactive and personalised care, service access and quality, workforce development, population health management and compassionate communities.	Implement SEL PEOLC action plan.	Assess the roll out, quantity and quality of advance care plans and their use.	Residents who are facing end of life receive high quality well co-ordinated care and support We will have assessed the roll out, quantity and quality of Advance Care Plans and their use.	Increased number of residents making informed choices about their end of life plans, with more using an advance care plan.
6. Service development	Undertake district nursing review to ensure capacity to meet local health needs and produce an integrated action plan.	Standardise and improve identification of moderate and severe frailty (including dementia) across primary and secondary care.	Create system dashboards for monitoring and improving service quality.	Frail older people receive safe, high quality interventions in the community.	An increase in the capacity of district nursing to meet local care needs.
	Ensure that people with frailty are not excluded by the new digital forms of access to primary care by supporting them to understand functionality and enabling proxy access for carers.	Ensure that qualitative data on all services that support frail older people is shared and used to enable an integrated approach to service improvement.			Number of digital champions recruited.
	Improve resident and relative voice. Listen to what they are telling us and work collaboratively with them so that we can improve the care and support we offer.				
	Develop a robust market sustainability and quality plan for home care and care homes .				

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