South East London Integrated Care System

Bexley Wellbeing Partnership

NHS South East London

Our population

The London Borough of Bexley has a population of 244,247. Bexley is experiencing the twin challenges of an ageing population toward the south and a relatively younger, ethnically diverse and deprived population towards the north. Bexley ranks 190 of 326 local authorities for deprivation and is the 9th least deprived local authority in London. However, there is considerable variation within the borough; 1 in 7 people live within the 30% most deprived areas nationally and around 1 in 6 children and 1 in 9 older people in Bexley are affected by income deprivation.

Health outcomes for our population

Obesity: High levels of obesity, including higher rates of childhood obesity.

Mental Health & Wellbeing: High prevalence of mental health problems and Bexley adults have relatively low self-reported wellbeing compared to London.

Emergency Admissions: Emergency hospital admissions for young children and babies are significantly higher in Bexley compared to London.

Frailty: Up to half of Bexley's population of over 65 years of age is affected by frailty, rising to 65% in those over 90 years of age.

Life Expectancy: Healthy life expectancy at birth for males is significantly higher in Bexley than the London and England averages and healthy life expectancy at birth for females is in line with regional and national averages.

Health Improvement:

Smoking – Less than 1 in 23 women smokers at time of delivery: less than a third of the number 10 years ago.

Cancer screening – For cervical cancer (50 to 64 years) Bexley performs above regional and England average and is third best in London.

Inequalities within our borough

Diversity: Bexley is expected to become more diverse and by 2045 Black, Asian and minority ethnic groups will account for an 30% of the population. Children from a Black minority ethnic background are significantly more likely to be overweight or obese. They are also two and half times more likely to live in the most deprived areas of Bexley, compared to children from a White ethnic background.

Borough Variation: There are stark inequalities in the north of the borough with approximately double the prevalence of reception age children identified as overweight and obesity compared to areas with the lowest prevalence.

What we've heard from the public

Develop and provide clear and simple messages on what and how to access the right services through our Roadmap to health and care:

- Improve access to same day urgent care and the quality of primary care
- Concerned about digital exclusion particularly for some of the most vulnerable communities
- Impact of the cost of living
- Provide services that are closer to where people live

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Bexley Roadmap to Health & Care – Our Priorities

The **Bexley Joint Local Health & Wellbeing Strategy (JLHWS)** identified **four points in residents' life journeys**, reflecting the biggest populations health and well being needs.

Improvements are being achieved through delivery of the **Joint Integrated Forward Plan** – the Bexley Wellbeing Partnership local system response to the JLHWS working and co-producing solutions with our local communities. Our approach:

- ❑ **Personalisation and promoting independence**
- ❑ **Focusing 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**

Bexley – Our progress to date

Start Well

Key Successes in Delivery in 2023/2024

- We have supported the local Safety Valve Programme by investing in therapy and nursing provision to new school places for Children & Young People (CYP) with Special Educational Needs (SEND).
- Targeted work in schools is in progress on eating disorder prevention (train the trainer model) and engagement on a new support model for LGBTQ+ young people.
- Bexley School Superzones Programme is underway in Thamesmead and Slade Green and includes projects supporting additional community food growing, creating healthier food environments in and around schools in areas of high need.
- Children's Centre staff have been trained in the *Henry* approach to healthier lifestyles as part of our drive to reduce the prevalence of overweight and obesity in the childhood population.
- 5 paediatric *Virtual Ward* beds have been opened for CYP and the team will be trialling the use of *Doccla* remote monitoring having secured additional funding through the national Health Technology Adoption and Acceleration Fund.
- The Bexley Maternity Voices Partnership was relaunched and held a development day in 2023.
- 84 GP practices referrals for patients were supported by our Children and Young people's Social Prescribing service delivered by Bexley Voluntary Service Council in partnership with Counselling Matters, Bexley Moorings, Cribs and Little Fish Theatre.

Key Challenges to Delivery in 2023/2024

- Investments and capacity constraints delayed commissioning and delivery of the Integrated Child Health Model – investment opportunities for 2024/25 are being explored.
- Whilst Child and Adolescent Mental Health Services (CAMHS) waiting times remains challenging, the Bexley CAMHS is restructuring to streamline access to initial assessment and additional investment is supporting this process.

Learning and Implications for Future Delivery Plans

- Renewed consideration of collective resources and investments, which enable discharge from Queen Elizabeth and Darrent Valley Hospitals to support the local health and care urgent and emergency care ecosystem.

Bexley – Our progress to date

Live Well

Key Successes in Delivery in 2023/2024

- Local Care Networks have continued to develop and mature – through integrated neighbourhood system working. The Local Care Networks *Reducing Health Inequalities Programme* in partnership with Public Health several neighbourhood level projects and services have been funded including; Improving Carers Mental Health by providing free counselling sessions; Supporting vulnerable families to improve nutrition and healthy weight on a budget, with cooking healthy food with low-cost ingredients training.
- Our new GP Premium, which supports GP Practices to deliver additional services was launched in 2023. The GP Premium targets reducing health inequalities by supporting residents with Learning Disabilities, improving screening uptake and providing proactive and personalised care to those with long-term conditions.
- We have provided additional investment to our Mental Health Hub, which is delivering on streamlined access to mental health services working in partnership with Oxleas NHS Foundation Trust and Bexley Mind.

Key Challenges to Delivery in 2023/2024

- Our Primary Care Networks continue to deliver on improving access to core primary care services and have been successful in ensuring that 75% of all GP appointments are face to face. Primary Care Networks continue to provide some of the highest levels of appointments overall – however the challenge remains in ensuring that residents receive consistent access and messages on how to access primary care services.
- Whilst our Primary Care Networks and Community Pharmacies have delivered over 37,000 COVID-19 booster vaccinations and continue to perform well on immunisation programmes – additional work is underway to support the national measles and MMR call and recall campaign, including targeted events in conjunction with Bexley Children's Centres to improve immunisation rates.

Learning and Implications for Future Delivery Plans

- Our expert communications and engagement team and programmes have enabled us to successfully reach many of our marginalised communities, the learning from these programmes will be embedded into future plans.
- The Bexley Wellbeing Partnerships ambition to reduce health inequalities at Local Care Network (Neighbourhood) level through population health approaches, requires significant support and engagement with our local communities – resources and expertise to ensure success and meaningful co-production are a prerequisite.

Bexley – Our progress to date

Age Well

Key Successes in Delivery in 2023/2024

- Our *Virtual Wards* provided 25 additional beds during Winter, enabling over 1,000 frail older people and those at the end life to be cared for in their own home.
- We successfully bid for additional funding for the *doccla* remote monitoring platform, which will be used increase the efficiency of the model. We have funded new *Home First* roles supporting Queen Elizabeth Hospital, signposting people to alternative support and early identification of complex care needs.
- We have provided additional investment Mental Health Hub, which deliver is delivering interventions and have provided streamlined access to mental health services working in partnership with Oxleas NHS Foundation Trust and Mind.
- We have been successful in improving Diagnosis rates for residents with Dementia, which is above the national target, work is underway to improve post diagnosis support.

Key Challenges to Delivery in 2023/2024

- The recruitment and retention of the necessary skilled workforce across all sectors continues to be a challenge
- Increased demand pressures for the local health and care ecosystem coupled with financial challenges impacted on the local systems ability to deliver meaningful and sustainable transformation programmes.

Learning and Implications for Future Delivery Plans

- Our integrated local health and care system reviewed our District Nursing Services and developed an action plan to ensure that our patients get the right care at the right time by the right health and care professionals. However, our review demonstrated that additional consideration will be required in developing support and services that meet the needs of our older population with frailty challenges.

Bexley priority action 1 – Start Well

Giving Children & Young People the best possible start

Children and young people were disproportionately impacted by the pandemic. We want all children and young people in Bexley to have the best start in life and recognise the importance of those early years in laying the foundation for future physical and mental well-being. Post-pandemic period there has been a worrying increase in the number of serious safeguarding incidents involving babies and children and young people. A joint approach to strengthening universal and targeted 0-19 years services and to hearing women's voices on maternity pathways with our three key maternity providers.

How we will secure delivery

Actions for 24/25

- Pilot Primary Care Networks Integrated Child Health Model
- Development of Single Point of Access for Child and Adolescent Mental Health Services.
- Local authority *Emotional Literacy Support Assistant* (ELSA)
- Ensure transition pathways for autism are reflected in the joint Autism Strategy
- Implementation of children's diagnostics and clinical management pathways for Asthma using Asthma nursing
- Establish working group to review pathways for 16-25 years transition for care leavers
- Subject to funding increase capacity of community the Sickle Cell service

Actions for 2025+

- Subject to funding, implementation of a single point of access for CAMHS
- Roll out Primary Care Networks Integrated Child Health Model targeting long-term conditions
- Focus on infant feeding, creating an environment for breastfeeding
- Developing Perinatal mental health support services

Intended outcomes in 5 years time

- Reduced waiting time for Child and Adolescent Mental Health Services
- Improved support for Children & Young People (C&YP) with long-term conditions, both physical and mental health
- Reduction in hospital admissions for C&YP
- Reduction in the numbers of woman smoking during and after pregnancy and of a healthy weight
- Better access to psychological therapies with specialist perinatal mental health services
- C&YP with special educational needs and disabilities (SEND) are identified early, reducing the need for escalation to more specialist services and are supported to access education in the borough
- C&YP are immunised against preventable diseases
- C&YP and their parents and carers, report feeling engaged in the process of assessing their needs and the criteria used to make decisions

Bexley priority action 2 – Age Well

Supporting frail and older residents to age well

Proportionally, Bexley has the **third-highest** age 65+ (41,000) population in London. There are an estimated **23,500** people in Bexley (50+) with **frailty**. Around **17,000 mild**, **4,300 moderate**, **1,800 severe**. Bexley has the **second highest** rate of emergency admissions for **falls** in London for people aged 65+. We will continue to closely evaluate our *Home First* approach to ensure that treatment and care is available in the right place at the right time and to ensure that people have timely access to reablement therapies to enable a return to an independent life. Our programme over the coming years will focus on: **1. Living well at home and reducing falls, 2. Living well in a care home, 3. Carer wellbeing, 4. Appropriate use of acute hospital provision, 5. Dying with dignity at home, 6. Service development.**

How we will secure delivery

Actions for 24/25

- 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
- 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. choice and control for residents
- Deliver new Trusted Partner model of reablement

Actions for 2025+

- Deliver targeted communications campaigns which promote opportunities to reduce social isolation and loneliness. Develop an integrated approach to technology enabled care
- Ensure that commissioning arrangements give greater protection to residents from eviction
- System-wide implementation of risk stratification tools and Comprehensive Geriatric Assessment to identify and assess those most at risk of hospital admission
- Review progress on delivering palliative end of life care priorities

Intended outcomes in 5 years time

- Reablement outcomes continue to improve (as measured by Adult Social Care Outcomes Framework)
- Fewer hospital attendances and admissions
- Frail older people are safely discharged in a timely manner
- Reduction in falls for frail older people
- Better identification of people with moderate and severe frailty
- Increase in recording of advance care plans
- More people can die at home or in the community with multidisciplinary support
- Expansion in the range of housing options to support Bexley residents later in life
- Increased uptake in physical activity by people with dementia and, separately, by carers
- Carers report good access to support in the community, including to address their physical and mental health needs

Bexley priority action 3 – Live Well (1)

Transforming Community Mental Health Services

Around 15,000 people in Bexley live in areas among the 20% most deprived in England, which is associated with at least a doubling of the risk of mental health problems. Prevalence of serious mental illness is Bexley is also associated with deprivation. People with serious mental illness in Bexley are more than 4 times more likely to die before the age of 75. Our community mental health services (CMHS) transformation plan takes a wellness approach to care planning. There is no 'wrong front door 'into services – movement between primary and secondary care should be seamless. We will take a multidisciplinary approach to assessing needs and use brief interventions and social prescribing to facilitate access to mainstream resources and activities. Our programme will prioritise**: 1. Personalised care closer to home for people with acute mental health needs, 2. Living well and working in the community, 3. Mental health and Local Care Networks, 4. Living well with dementia and 5. Support for those at risk of suicide**

How we will secure delivery

Actions for 2024/25

- Expand neighbourhood hubs to enable to access timely personalised support to prevent a crisis
- Improved community out of hours crisis services
- Progress development of mental health rehab capital programme
- Improve housing options for people with mental health issues
- Expand care homes support for people with dementia
- 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
- 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

Actions for 2025+

- Deliver plans to ensure the supply of housing solutions and community rehabilitation in line with the borough's mental health needs trajectory
- Embed a sustainable and resourceful VSCE sector to support people with mental health needs and reduce mental health inequalities across the borough, including at Local Care Network level

Intended outcomes in 5 years time

- Residents with acute mental health needs will receive personalised care in the right place and the right time closer to home
- 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
- 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
- Community mental health services are embedded in Local Care Networks, and providers work in partnership to intervene early an
- 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 prevent escalation
- Reduce the number of suicides and increase support for those affected by suicide

Bexley priority action 3 – Live Well (2)

Supporting people to maintain a healthy weight

Obesity is one of the biggest health challenges for Bexley and is a family issue. Children living with obesity are more likely to become adults living with obesity and thus increases the risk of obesity for their own children later in life. Close to two-thirds of adults are overweight, with more than a third of 10-and 11-year-olds being obese. Just under 1 in 4 (22.9%) children starting primary school are obese or overweight; Prevalence of obesity is significantly higher than in London and England, which is more apparent in the north of the Borough. 1 in 3 (38.5%) children leave primary school obese. Bexley 1 in 6 children who enter primary school not overweight leave primary school overweight. Our local health and care system action plan has 3 key priorities; **1. The food and physical activity environment 2. Embedding healthy lifestyles, and 3. Support for individuals**

How we will secure delivery

Actions for 24/25

- Explore opportunities around Healthy Streets for new developments, including encouraging active travel
- Upskill community health champions to signpost residents into appropriate areas of support
- Implement the Football Foundation Playzone programme and activate the spaces with the community
- Develop a segmented communications plan on healthy lifestyles with communities and other stakeholders
- Using school health profiles consider what additional support can be provided to schools with high rates of obesity
- Focused work with the Local Care Network (LCN) with the highest rate of obesity, aiming to reduce inequalities
- Integrated weight management offer within the new 0-19s Public Health Service, supporting families and primary school age children.

Actions for 2025+

- Develop a wider food action plan / strategy for Bexley
- Explore opportunities for local employers to support a healthier workplace
- Evaluate tier 2 adults weight management service at year 2

Intended outcomes in 5 years time

- Reduction in the rate of excess weight in children and adults by a minimum of 2% over five years, with a stretch target of 5%
- Ethnic minority children most at risk and their families are better supported and can access the right services
- Increase in the number of ‘healthy places for all’ in Bexley
- Increase in healthy environments at school, in workplaces and throughout Bexley
- Healthy weight is promoted in all health and care settings
- Improved access weight management services
- Consistent and early identification in Primary Care
- Early identification and support for children and young people in primary care

Bexley priority action 3 – Live Well (3)

Local Care Networks delivering preventative services and improving population health

Bexley Care was established in 2018 and is a consortia between the London Borough of Bexley Council and Oxleas NHS Foundation Trust. Joint integrated neighbourhood teams are delivering services that provide community, mental health and learning disability services, and adult social care – using a matrix approach. The integrated neighbourhood teams deliver services within the 3 established Local Care Networks geographies; Clocktower, Frognal and North Bexley. Our priority action is for the Bexley Care integrated teams to develop and evolve as a neighbourhood 'team of teams' and include the 4 Primary Care Networks and other primary care providers, reflecting recommendations of the Fuller Stocktake. 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.

Actions for 24/25

Actions for 2025+

How we will secure delivery

- Local Care Network Asset Mapping to support understanding and identification of neighbourhood need and requirements
- Adopt a 'Plan, Do, Study, Act' approach in developing of early interventions and services
- Create a bank of evidence-based interventions that deliver better outcomes and reduce inequalities at neighbourhood level
- Implement Year 2 of the Health Inequalities Programme for Local Care Networks
- Co-produce the community activation programme

- Develop estates plan for Local Care Networks to enable the delivery and co-location of services closer to where people live
- Review of *Population Outcomes Through Services* and self-assessment.

Intended outcomes in 5 years time

- Bexley Local Care Network Population Health & Care Profiles are in place and accessible to all
- Primary Care Networks are integral to neighbourhood 'teams of teams' with pragmatic and long-term support established
- The Bexley Local Care Network Operating Model ensures standardised governance and infrastructure to support and empower neighbourhood teams
- Local Care Networks and neighbourhood teams develop interventions and services that support with long-term conditions, addressing inequalities and improve health outcomes for neighbourhoods
- Local residents, community leaders, VCSE and key stakeholders are activated to be engaged and involved in co-producing services and interventions in their neighbourhood

Bexley – Local Delivery

Bexley borough delivery of SEL pathway and population group priorities

The Bexley Wellbeing Partnership is developing its *3 Joint Forward Integrated Improvement Plan*, which represents and reflects its commitment to the Bexley Joint Local Health & Wellbeing Strategy. Local health and care partners will agree a series of meaningful and sustainable 'system' actions that will support improving access and outcomes for residents in the priority areas; Ensuring *Children & Young People start well, Supporting our frail and older residents to age well, Tackling obesity and delivering our Community Mental Transformation Programme.* The partnership is committed to delivering the SEL pathway and population group priorities and some examples of local delivery are shown below.

Example of local delivery – Prevention

Primary Care Network Practitioners will collaborate across primary and secondary care teams to increase uptake of annual health checks for people with **Severe Mental Illness**. This will be delivery through; improved information transfer and recording; and working with local health and care partners will develop referral pathways for further support e.g. healthy weight and drug and alcohol interventions.

Example of local delivery – Health Inequalities

The Bexley Wellbeing Partnership utilising its Health Inequalities Fund has developed programmes at the 3 Local Care Networks geographies – using the Local Care Network Health & Care Profiles developed by the London Borough of Bexley Council. The programmes and interventions have prioritised increasing cancer screening take-up, supporting frail older residents and children and young people and developing the community voice. The **integrated neighbourhood teams**, VCSE and key stakeholders including social housing and community leaders lead on development and delivery.

Example of local delivery – Urgent & Emergency Care

The Bexley Wellbeing Partnership is recommissioning local urgent care services located at **Queen Mary's and Erith General & District Hospitals**, to support development of a; A **simplified same day integrated urgent care pathway** where patients are confident about where to go for treatment, offers **holistic**, consistent quality of care, are **financially sustainable** and continually evolve to **meet the changing urgent care** needs of Bexley.

Example of local delivery – Primary Care

The Bexley Wellbeing Partnership is commissioning a 3 year Personal Medical Services Premium for GP Practices. It will support GP practices with improving take-up rates for; screening for **Bowel and Breast Cancers** – particularly for those with **learning disabilities**, immunisations and providing **personalised** and proactive care for the management of **long-term conditions**.

Bexley enabler requirements

Workforce

Retention: Ensure staff, volunteers and unpaid carers feel valued and empowered to act to do what is right for the people they care for.
Recruitment: Create opportunities for personal development including working across the health, local government and VCSE sectors in neighbourhood teams.
System Working: Maximise the national Additional Roles & Responsibilities Scheme ensuring retention and defined career pathways, supported by wider system and of new model of workforce supports delivery of primary care services.

Estates

System Planning: Rationalisation of current Estate and ensure health and care premises are fit for purpose and in good condition. Increase integrated working where providers and services are co-located.
Securing Investment: Continue to progress optimisation programme across the borough and levering funding for new developments including the Community Diagnostic Centre and neighbourhood hubs.
Primary Care: Maximise funding opportunities to understand the clinical capacity required for Primary Care Networks to inform future investment and priority primary care estates projects to improve access.
Delegation: Primary care estates budget and decision making delegated to the partnership.

Digital

- Developing an integrated approach to **population health**/public health improvement.
- Mapping the different IT systems being used by different organisations and the need for **interoperability** – including hospital data in shared care records and population health data.
- Develop our **business intelligence** capabilities to aggregate a spectrum of demographic, health and care data.
- Create a data driven culture with 'one version of the truth' across the partnership, making evidence-based decisions.
- Creating shared dashboards for **shared outcomes** and joint activities/tasks for the partnership's priorities and within the Local Care Networks.
- Accurate identification of individuals and cohorts across health and social care is needed to ensure success.
- **Artificial Intelligence:** Bexley GP practices are actively piloting Artificial Intelligence (AI) solutions to support with time consuming administrative functions e.g. Healthtech-1 which supports the automation of new patient registrations.

Finance

- Sustainable funding for the VCSE to deliver local programmes and initiatives.
- Development of a **'pooled budgets'** partnership approach to support maximising the ***Bexley £***. Consider funding shifts where Bexley are outliers across the local health and care system.