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 · 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.

Bexley - Our objectives and priority actions

Our key objectives – what we want to achieve over the next five years

We have three priority objectives for integrated improvement in Bexley: **1. Improving people's health and wellbeing across the life journey; 2. Improving access to our health and care services; and 3. Addressing health and care inequalities**. Our aim is to support residents across their entire life course 'start well, live well and age well'. Through our Joint Local Health & Wellbeing Being Strategy together with residents we have prioritised four key priority areas across the life course: Children and Young People, Frailty, Obesity and Mental Health. Cross cutting themes include focus on **personalisation, early prevention and population health**.

Our priority actions

1. **START WELL – Giving Children & Young People the best possible start**: Prevention and early identification of physical and mental health conditions, improving access to mental health support, and reducing waiting times for Children and Adolescent Mental Health Services.
2. **AGE WELL – Supporting Frail and older residents to age well**: Deliver on our 3 three commitments to our frail and older residents.
3. **LIVE WELL – Transforming Community Mental Health Services**: Our community mental health transformation programme takes a wellness approach to care planning. There is no 'wrong front door' into services and movement between primary and secondary care should be seamless.
4. **LIVE WELL – Tackling Obesity**: We intend to create a local environment that supports everyone to have a healthy weight, to halt the rise of excess weight among children and adults and create a downward trajectory by 2025.
5. **ENABLERS – Neighbourhood Teams**: Bexley will deliver improvements to accessing health and care services and addressing health inequalities – through our joint neighbourhood teams located in **Local Care Networks**. Our 3 Local Care Networks, Clocktower, Frognal and North Bexley will have a common core offer; and a local offer derived from our Local Care Networks Health and Care Profiles, system stakeholders, Primary Care Networks and our community voice. **Primary Care Networks**: Developing programmes to support our 4 Primary Care Networks as part of our established neighbourhood teams and deliver improved access to core services. **Community Activation**: We will co-design pathways with residents to help them understand how best to access health and care services. We will continue to build on and support our 518 Community Champions. We intend to place our team/s in the community to listen and engage with residents. We will support and develop Voluntary, community and social enterprise sector (VCSE) as partner providers of services.

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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 services and to hearing women's voices on maternity pathways with our three key maternity providers.

How we will secure delivery

Actions for 23/24

- Pilot Primary Care Networks Integrated Child Health Model
- Development of Single Point of Access for CAMHS
- Strengthen Local Care Partnership Standard Operating Procedure
- Work to prevent eating disorders and support Mental Health of Lesbian, gay, bisexual, transgender, queer or questioning and others (LGBTQ+) C&YP through targeted work in schools
- Embed Maternity Voices Partnership to identify improvements to maternity care and continue projects through stop smoking in pregnancy steering group
- Support the health interface of Bexley school expansions into Shenstone secondary school

Actions for 24/25

- 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

- Reduce CAMHS wait-times in line with agreed 2023/24 target
- Improved support for Children & Young People (C&YP) with long-term conditions, both physical and mental health
- Reduction in hospital admissions for C&YP
- Fall 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.

How we will secure delivery

Actions for 23/24

- Embed *Home First* approach to hospital discharge
- Roll out year 2 of *Virtual Frailty Ward* including End of Life, rapid response services
- Review district nursing services to support housebound people and enable choice of place of death
- Develop 2 hour Urgent Care Response
- Evaluate dementia care home support multi-disciplinary team

Actions for 24/25

- Develop opportunities for extra care housing
- Review and develop falls prevention services
- Co-produce support for carers of frail older people and people with dementia through the Carers Partnership.
- Standardise identification of moderate and severe frailty across primary and secondary care

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.

How we will secure delivery

Actions for 23/24

- Deliver year 3 of CMHS transformation plan
- Develop systems to screen residents using psychological community assets approach
- Mobilise neighbourhood hubs to encourage wider use of direct access services
- Refresh dementia diagnosis action plan and evaluate older people multidisciplinary approach to care home dementia support
- Progress mental health rehab relocation capital project

Actions for 24/25

- 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

Intended outcomes in 5 years time

- Residents with acute mental health needs will be cared for as close to home 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 and prevent escalation
- Dementia diagnosis and post diagnostic support is equally accessible to all our communities
- Residents and their carers are supported to live in the community for as long as possible
- People with severe mental illness will have personalised care planning to improve their physical health and normalise their life expectancy

Bexley priority action 3 – Live Well (2)

Tackling Obesity

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.

How we will secure delivery

Actions for 23/24

- Review of the Bexley 5 Year Obesity Strategy and action plan in light of the COVID-19 Pandemic
- Develop programmes that support easy access to information, healthy food and creating a healthy food environment
- Develop a 'Family approach'
- Target support at those that need it most and tailor support to meet different communities

Actions for 24/25

- Create a healthy physical activity environment – so it is easy to be physically active
- Develop communications and engagement programmes that makes a obesity a cause and a 'call to action'
- Secure sustainable funding sources to support the development of interventions at Local Care Network level delivered by local communities

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

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.

How we will secure delivery

Actions for 23/24

- Development of the Bexley Local Care Network Operating Model
- Recruitment of Clinical/Care Professional Leads to partner with *Bexley Care* Local Care Network Associate Directors
- 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

Actions for 24/25

- Create a bank of evidence-based interventions that deliver better outcomes and reduce inequalities at neighbourhood level
- Develop estates plan for Local Care Networks to enable the delivery and co-location of services closer to where people live
- Implement Year 2 of the Health Inequalities Programme for Local Care Networks
- Co-produce the community activation programme

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 Year Plus 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 will be developing programmes at the 3 Local Care Networks geographies – using the Local Care Network Health & Care Profiles developed by the London Borough of Bexley. The **integrated neighbourhood teams**, VCSE and key stakeholders including social housing and community leaders will 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 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, which will commence in 2023/24. 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.

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.