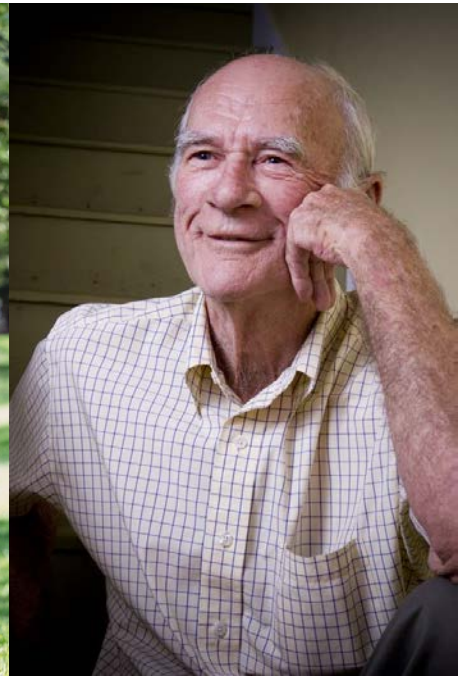
A Health and Wellbeing Strategy for Bexley



NHS Bexley Clinical Commissioning Group

LONDON BOROUGH OF BEXLEY

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FOREWORD

Health and wellbeing is everybody's business, and our joint aim is to improve the health of all Bexley residents. We know we face real challenges around increases in demand for health and social care services, coupled with increasingly complex health issues amongst our local populations. Tackling these challenges will require ambitious thinking, a strong desire for change, and a willingness for all partners and residents to work together to develop new approaches that deliver improved health outcomes. The role of the Health and Wellbeing Board is to enable and co-ordinate this joint work.

This is the first health and wellbeing strategy for the residents of Bexley. Using the borough's 2011 Joint Strategic Needs Assessment (JSNA), the Bexley Health and Wellbeing Board has considered what affects the health of our residents the most, and the conditions we need to tackle as a priority. By using the best data available to us, and taking into account what people tell us, we know that obesity, diabetes, the increasing cases of dementia, and use of tobacco, alcohol and drugs are currently having the greatest impact on the health and wellbeing of people in our borough.

This health and wellbeing strategy aims to target our joint resources to tackle these issues over the next three years. Our partners are all working in a difficult economic environment, and delivering real improvements will be challenging. We will therefore need to be innovative in what we do, and will need to harness experience and contributions from all sectors of the health economy in Bexley including the public, private, voluntary and not for profit sectors, and our residents.

At the same time, we are seeing significant change in the way health services are delivered in Bexley and across south east London. Keeping people out of acute hospital based services and treating them close to home is considered best for the patients' wellbeing, and the way we operate services will need to change to reflect this. We have identified a number of transformation priorities for the borough which will help us to work better together to deliver this new approach.

This strategy will be underpinned and delivered through a range of more detailed strategies and plans, and these will be reviewed regularly.

OUR VISION

We want people in Bexley to be healthy, happy and resilient, and we believe that everyone has the right to access good health and care opportunities. We want these to be joined up, high quality and safe, and when services are used we want residents to have a positive experience of the care they receive. However, we cannot achieve this alone and we believe that good health is everyone's responsibility and requires everyone to play their part. Individuals need to take good care of their own health and that of their families and friends by choosing healthy options and healthy lifestyles. We can support this by developing preventative services and creating an environment so that people can make informed choices about their health and the way in which they live.

THE BEXLEY HEALTH AND WELLBEING BOARD

There is increasing emphasis on the need for local government, GP's, other NHS organisations, the voluntary and not for profit sectors to work together, to develop a shared health vision for our borough with joint commissioning and integrated delivery pathways. There is a specific leadership role for local government, and a clear emphasis on the need for people to engage with and take care of their own health. Bringing all of this together is the purpose of the Bexley Health and Wellbeing Board.

The Board's work to deliver its vision for the future needs to be underpinned by a shared understanding of local needs (as set out in the Joint Strategic Needs Assessment (JSNA)) and an overarching and co-ordinating framework for delivery (the Health and Wellbeing Strategy). These documents set out the borough's health priorities, inform commissioning decisions, determine resource allocation and support our joint work to improve health and wellbeing outcomes.

We hope that by working closely as a partnership we can make a real difference to the health and wellbeing of Bexley residents.

WHAT WE KNOW ABOUT THE HEALTH AND WELLBEING OF OUR RESIDENTS

In general the health of people in Bexley is varied when compared to the England average, with life expectancy for both men and women higher than the England average. There are some health measures where we are performing well (for example, early death rates from cancer, heart disease and stroke have fallen) but in others (childhood and adult obesity, adult physical activity, starting breastfeeding, people diagnosed with diabetes) we are significantly worse than the England average, and need to take action to improve. Bexley residents experience some health inequalities, with the 2013 Health Profile showing life expectancy for men living in the most deprived parts of the borough as nearly 7.8 years lower than for men living in the least deprived parts of the borough. For women, the difference is 3.4 years. The changing make up of our communities, particularly the increase in the number of older people, will see a rise in conditions associated with older age such as dementia.

THE BEXLEY PRIORITIES

Our health and wellbeing priorities have been drawn from the Bexley Joint Strategic Needs Assessment (JSNA), information from the Public Health Outcomes Framework (including adult and child health benchmarking data) and consultation with our residents. Using this evidence base we have identified four health priorities that impact most on the wellbeing of people in Bexley :

- Tackling childhood and adult obesity
- Diabetes
- Supporting people with addictions – including smoking, alcohol and drugs
- Dementia

In addition to the health priorities listed above we have identified key changes that we want to make in how health and social care services are delivered in Bexley.

- Improving services at Queen Mary's Hospital in Sidcup
- Joining up health care with social care and keeping more people out of hospital
- Improving Primary care
- Investing in prevention services

Extensive consultation was undertaken on the draft strategy during summer 2013. Key feedback included:

- The majority of respondents who responded agreed with the priorities
- Additional areas were suggested as priorities – particularly mental health and wellbeing, alcohol misuse, and support for the elderly and disabled.
- Strong support for the development of Queen Mary's Hospital and support for services to be provided locally in the borough
- Some concern regarding access to GPs

The strategy has been updated as a result to prioritise all addictions – tobacco, alcohol and drug misuse - rather than just tobacco. Mental Health and support for the elderly and disabled will be priorities for review in the 2013 Joint Strategic Needs Assessment. The transformational priorities in the strategy have also been updated to reflect comments from residents.

HOW WE WILL MAKE A DIFFERENCE

The next section of the strategy sets out the actions we propose to take to address each priority over the next 3 years.

These actions will be delivered through the corporate and commissioning plans of all partners on the Health and Wellbeing Board. We will work closely with all relevant organisations in the borough, including the many groups from the local community and voluntary sector, to deliver the impact that we need.

The strategy is not a full list of everything we will do, and work to improve a wide range of other health conditions and local services will continue alongside the Health and Wellbeing priorities. Further information on some of the actions we are taking is set out in joint strategies such as those covering Carers' support, Autism and End of Life.

The Health and Wellbeing Strategy will be revised after one year to reflect revisions to the Bexley Joint Strategic Needs Assessment. Any changes will be reported through the Bexley Health and Wellbeing Board.

Priority 1

Tackling Childhood and Adult Obesity

What is the issue?

Studies have shown that obesity reduces life expectancy by an average of three years, while morbid obesity reduces it by 8 years – the same effect as a lifetime of smoking. This is because being obese can increase the risk of developing a range of diseases and health problems such as coronary heart disease, stroke and some cancers. Other potential health effects include musculoskeletal problems, from wear and tear in the joints to back pain, mental health and social issues.

In Bexley, the levels of adult obesity are significantly higher than the England average and the percentage of adults who are obese is higher than all other local authority areas in south east London. We currently have approximately 60,000 people in the borough who are obese. The estimated level of physical activity amongst adults in Bexley is also worse than the England average.

The number of obese children entering and leaving primary school in Bexley appears to be worsening.

We will:

- Develop a multi-agency Obesity Plan for Bexley.
- Follow the Council's ongoing commitment to prevention by providing and publicising existing opportunities in the borough for families, children and individuals to be more active.
- Maximize the impact on obesity of all partners' existing activity, programmes and contracts, for example supporting schools to help children and young people eat a healthy diet and be more active; working with early years settings and health visitors to encourage breast feeding and healthy eating.

- Join up services better, e.g. so that GPs can give clear information to patients about activities available in their local areas that might support healthy eating and exercise.

- With GPs and other professionals, develop effective care pathways for adults and children who provide appropriate specialist support for those identified as being overweight or obese.

- With partners and GPs review the current exercise on referral programmes and look at how any gaps may be addressed.

- Provide early structured support through health trainers and family support, so that families and individuals who wish to do so are encouraged to make lifestyle changes.

- Commission evidenced-based weight management programmes for adults, children and their families. These will be sustainable, and evaluated to ensure success.

- Work with partners to target those communities who are known to be less physically active and create Community Activation schemes that enable and encourage groups of people to work activity into their daily lives.

- Use communications effectively to provide people with the information they need to chose healthy lifestyles. Join up local messaging with regional (mayoral) and national campaigns.

- Promote a healthy environment through policy development such as improvements to our towns, streets and roads, a healthy workplace and improvements to the cultural environment.

- As local employers, encourage our staff to adopt healthy lifestyles e.g. by making it easier to cycle to work, promoting and providing healthy eating options etc.

- Work with local fast food businesses who are keen to improve their healthy eating offer

- Ensure the Bexley Health and Wellbeing Board drives and evaluates the impact of the initiatives outlined in the Obesity plan.

We will have succeeded if, by 2015:

- An Obesity Plan is in place and the agreed actions are being delivered.
- More adults and children in the Borough are being more active.
- More women are breastfeeding their babies.
- There are more residents participating in a range of activities to help lose weight.
- Over time we see levels of obesity leveling off in the Borough.
- Positive messages about healthy living are prominent in the Borough.

Priority 2

Diabetes

What is the issue?

Diabetes is a long term condition that has been on a steep increase over the last 10 years. It develops when there is either no insulin in the body to allow glucose to enter the body's cells to be used as fuel (Type 1 diabetes); or not enough insulin or the insulin there is doesn't work properly (Type 2 diabetes).

The most common major complications as a result of diabetes are heart disease or stroke. Other complications include renal failure, ulcers and amputations, and eye problems potentially leading to blindness.

This disease is the single most common cause of blindness in the working age population in the UK and foot problems caused by diabetes are one of the leading causes of disability and the need for social care support.

Treating diabetes is a significant and growing challenge for Bexley. As obesity is a significant risk factor for diabetes and with higher than average levels of inactivity in the borough, it is not surprising that Bexley has a higher rate of diabetic patients diagnosed compared to the UK average. Locally, prevalence rates have more than doubled since the early 90s and are expected to rise further. There is variation in the quality of care received by diabetic patients in Bexley. In particular, staff may not have access to essential training and specialist support, and patient access to information and advice is inconsistent.

We will:

- Develop a multi agency Diabetes Plan for the borough.

- Improve the identification of patients with pre-diabetes (glucose intolerance) through NHS Healthchecks and develop preventative programmes for this group of patients.
- Develop further plans to improve early detection rates, particularly though GP Healthchecks, and through partnership working with the voluntary sector.
- Work closely with colleagues within Bromley and Greenwich to develop a model of care for diabetes patients which provides a more streamlined service and ensures consistency of treatment.
- Commission a new integrated diabetes service to encompass the whole diabetes care pathway, delivered through a single provider organisation. This organisation will be responsible for co-ordinating all diabetes care whether delivered in primary, community or secondary care. This approach will address the issue of growth in the prevalence of diabetes and the need to improve the overall quality of service provision.
- Deliver as much diabetes care as we can in the community, reducing the need for residents to be in hospital.
- Make chiropody clinics more accessible to patients and ensure that full foot assessments are provided whenever a patient attends a diabetes clinic.
- Enable more patients to self manage their condition, including type 2 diabetes, through the development of an annual review process.
- Ensure there is sufficient availability and capacity of Paediatric support for children with diabetes.

We will have succeeded if, by 2015:

- The rise in incidence and prevalence of diabetes in the borough has slowed.
- There is more information available to residents about the risk of diabetes and how to prevent Type 2.
- The views of the patients has been heard and acted on in the development of treatment programmes for diabetes.
- The new integrated diabetes service has been commissioned and is operational, and GPs are working well with the new prime contractor as part of the integrated model of care.
- The number of diabetic patients receiving in- patient care has reduced.

- Those with diabetes are able effectively to manage their condition and the Bexley General Practice Scheme is effective in supporting this.
- There is improved support for children with diabetes and their parents.

Priority 3

Supporting people with addictions – including smoking, alcohol and drugs

What is the issue?

Smoking: Guidance from the National Institute for Health and Care Excellence (NICE) states that Tobacco use is the single greatest cause of preventable deaths in England – killing over 80,000 people per year. This is greater than the combined total of preventable deaths caused by obesity, alcohol, traffic accidents, illegal drugs and HIV infections. One in every two regular smokers is killed by tobacco, and half of them will die before age 70, losing an average 10 years of life. The 2013 Bexley Health Profile shows that adult smoking is slightly better (lower) than the England average, as is smoking in pregnancy.

Alcohol: NICE advises that alcohol consumption is associated with many chronic health problems including psychiatric, liver, neurological, gastrointestinal and cardiovascular conditions and several types of cancer. Drinking during pregnancy can have an adverse effect on the developing foetus. Alcohol is also linked to a number of social problems, including recorded crime assaults and domestic violence. The impact on other family members can be profound, leading to feelings of anxiety, worry, depression, helplessness, anger and guilt. The 2013 Bexley Health Profile shows that hospital stays for alcohol related harm are better (fewer) than the England average. Alcohol - specific hospital stays for under 18s are also better (fewer) than the England average.

Drugs: Drug misuse is when a person has a problem with illegal drugs (such as heroin, cocaine or cannabis) or becomes dependent on them. Being dependent on a drug can lead to physical illness, mental health problems, relationship problems and financial difficulties. The 2013 Bexley Health Profile shows that drug misuse in Bexley is better (lower) than the England average.

Addressing alcohol and drug misuse is a challenging issue for Bexley. Client complexity is increasing, resulting in a higher proportion of clients presenting to treatment with compromised mental health, physical health complications and high risk injecting behaviour. As a result, Bexley's treatment system needs to be flexible in order to adapt to meet these changing, and sometimes unpredictable needs. Bexley's treatment

system is focussed on recovery, whereby all clients are offered sufficient opportunity and support to leave the treatment system free of all substances, where this is appropriate. This requires engagement from a range of partner agencies, including employment, training and education services, housing services, primary care and family/relationship support services.

We will:

- Work in partnership with mental health services to provide appropriate joint treatment to those with a dual diagnosis of substance and mental health issues.
- Fully roll out procedures to identify offenders who have 'class A' drug addictions at point of arrest and engage them in appropriate drug treatment.
- Use conditional cautioning effectively to engage drug and alcohol misusing offenders in treatment programmes and ensure the full implementation of the Restrictions on Bail process.
- Review and procure specific drug and alcohol treatment services to ensure the treatment system is fit for purpose in light of increasing client complexity. We will commence with the procurement of inpatient and residential treatment provision during 2013/14.
- Expand our prevention work in schools and work more extensively with voluntary and community groups.
- Work with partners to develop a multi-agency Tobacco Control Plan for Bexley. This will be a three year plan which will be refreshed annually. A monitoring and evaluation framework will be built into this plan to enable us continually to audit the success of interventions.

- Ensure Bexley's Stop Smoking Service continues to reduce prevalence of smoking in Bexley, targeting those most affected by health inequalities.
- Build on our existing enforcement activity around sales of tobacco and alcohol to those who are underage.
- Implement the 'Point of Sales' display legislation and promote a smoke free Bexley through workplace policies and promotion of no smoking in parks (in particular in children's play areas) and bus shelters.

- Tackle illegal trade in tobacco products to protect young people.
- Deliver programmes which aim to reduce the uptake of smoking by young people.
- Promote smoke free environments to protect children from the harm of passive smoking.
- Promote the Bexley Stop Smoking service so that residents know how to access support.
- Ensure that our Trading Standards Team will continue to participate in London-wide trading standards project investigating the usage of self-storage facilities for keeping illegal tobacco.

We will have succeeded if, by 2015:

- We have jointly agreed processes in place with mental health services to address issues of dual diagnosis.
- Flexible inpatient and residential treatment options are in place for those with complex drug and alcohol addictions.
- Processes for identifying substance misuse at the point of arrest are fully embedded and are resulting in an increase in referrals to treatment programmes.
- We have implemented all elements of the multi-agency Tobacco Control Plan.
- There is a decrease in the number of smokers in the borough.
- Our programmes for supporting those with drug addiction are working well and people are maintaining a drug free lifestyle after treatment.
- There is a reduction in the illegal trade in tobacco products.
- A communication plan to tell people how to access support to stop smoking is in place and is effective.
- Positive messages about the benefits of not smoking and reducing alcohol are communicated by all Health and Wellbeing Board partners.
- Our work with children and young people is having an impact and we see a reduction in young smokers.

Priority 4

Dementia

What is the issue?

Dementia describes a group of symptoms including memory loss, confusion, mood changes and difficulty with day-to-day tasks. The two main types of dementia are Alzheimers and vascular dementia. There are several diseases and conditions that can cause dementia, with Alzheimer's the most common. Dementia is progressive, which means the symptoms will gradually get worse. How fast dementia progresses will depend on the individual, what type of dementia they have and the action they take towards maintaining an active mind and body.

In Bexley, there are estimated to be 2,890 people with dementia and it is predicted that this will increase by 10% to 3,180 people by 2020. In response, multi-agency work is underway to deliver services and improve outcomes for people with dementia in line with the National Dementia Strategy. Locally, we are taking steps to improve the patient journey from diagnosis through to end of life care.

We want to support people with dementia and their carers to remain in their own homes and live as independently as possible. This is achieved through the provision of a range of services, including telecare, carer's support and specialist home care services. Our specialist dementia worker helps people with moderate to severe dementia to stay at home for longer by providing intensive support and linking in with existing services. This work prevents or delays admission into hospital and permanent residential or nursing care.

Staff involved in the support and care of people with dementia need to have the necessary skills to provide the best quality of care. This can be achieved through effective basic training and continuous professional development. We will continue to engage with providers to promote dignity in care and ensure personalised support for people with dementia across a range of settings, including care homes.

Many people with dementia are reliant upon family carers to support them. Family carers of people with dementia are often old and frail themselves and have high levels of carer burden with high levels of depression and physical illness and a diminished quality of life. Through the Bexley Health and Wellbeing Board, we have worked with the NHS and the voluntary sector to develop a Carers Strategy. Through its implementation, we aim to improve the support available to all carers, including those caring for people with dementia.

We will:

- Work collaboratively with people with dementia and carers to develop a joint Dementia action plan which raises awareness and understanding of dementia, particularly in primary care.
- Ensure that the NHS Healthcheck programme identifies people at risk of vascular disease and raises awareness through a new dementia assessment element of the healthcheck.
- Continue to develop solutions which promote independence for older people, particularly focusing on providing more opportunities for residents to receive care and support at home. This includes continued access to telecare, as a standard part of care packages, and the development of telehealth initiatives.
- Commence work on developing an integrated care pathway for dementia that is part of the General Practices performance framework.
- Increase the way dementia is identified early through screening for over 65 years within General Practices as part of the annual NHS Health check system.
- Increase public awareness of dementia and how it affects individuals, including the development of information resources, such as a 'Guide to Dementia Services'.
- Ensure patients are involved in the development of new services.
- Improve early diagnosis and early interventions, e.g. memory clinics.
- Invest in voluntary sector prevention services, specifically to provide a Dementia Hub, comprising access to Dementia Advisers within the Borough, a Carers Information and Support Programme, a Dementia Café, and activity groups.
- Develop a plan to deliver a dementia training framework for NHS, Council and other partners' staff .
- Develop a programme to improve dementia care in acute hospitals, residential and nursing care homes.
- Deliver the 'Dementia Inspired Gardens' project to improve the garden areas of local care homes for residents with dementia.

- Work with Oxleas NHS Foundation Trust to develop alternative models of care, involving additional intensive support for dementia patients in their own home or in care homes.
- Review palliative and end of life care arrangements and plan seamless services for dementia patients and their carers.

We will have succeeded if, by 2015:

- We provide sound advice and information to help people with dementia and their carers receive support and understand dementia care pathways.
- We have developed new models of care to promote early intervention to support people with dementia to live at home.
- We have improved acute hospital dementia care.
- We see improvements dementia care in residential and nursing settings.
- Early diagnosis in primary care has improved.
- People with dementia and their carers feel they have been contributed in the design of services.

Transforming the way we work

In addition to the four health priorities we have highlighted four key changes that we want to make to how health and social care services are delivered in Bexley.

- Improving services at Queen Mary's Hospital in Sidcup
- Joining up health care with social care and keeping more people out of hospital
- Improving Primary care
- Investing in prevention services

Improving services at Queen Mary's Hospital , Sidcup

The London Borough of Bexley and the Bexley Clinical Commissioning Group (CCG) have developed detailed plans to secure the future of Queen Mary's Hospital in Sidcup. Working with partners such as Oxleas NHS Foundation trust, the site will be revitalized and used more effectively to provide a range of health services for local people. The Secretary of State for Health has agreed with this vision for the future for the hospital, and local plans will now move forward to reconfigure the site and the services provided.

The hospital will specialise in dealing with the day-to-day healthcare needs of local people, with social care and health services working together. As part of a major refurbishment plan, £30m will be invested over the next three years to bring services and buildings up-to-date, and ensure that people receive good-quality, efficient services in welcoming surroundings. As part of the improvements, several local organisations are teaming up to provide services focusing on each patient's needs.

This three-year plan means QMH will be one of the first 'community-facing' hospitals of its kind in the country. Its new approach will see more joined-up work with other local health and social care services, meaning fewer people will need to be admitted to hospital.

Core services at the site will include:

24-hour unscheduled care, including an urgent care centre and GP out-of-hours service	Older people's services
Children's services, including the children's development centre and paediatric walk-in unit	Specialist services, such as chemotherapy
Community midwifery services, linked to the hospitals where women from Bexley give birth	Outpatients services, such as general surgery, gynaecology and paediatrics
Day surgery	Diagnostics, including scans, ultrasound and x-ray
Therapies, including physiotherapy and occupational therapy	Inpatient mental health services for local patients
Community and inpatient neuro-rehabilitation services	

Joining up health care with social care and keeping more people out of hospital

Improved outcomes across the whole health and social care system can only be achieved when all parts of the system work together. Bexley's Integrated Commissioning Unit was established in December 2012 to improve the way partners jointly buy and deliver health and care services. Membership includes GPs, the Council, the Clinical Commissioning Group and the voluntary sector. Supported by the Bexley Health and Wellbeing Board, the new approach enables partners to align their services and use expertise across the system to ensure the services local resident receive are both cost effective, high quality, and joined up.

The Council and Oxleas NHS Foundation Trust are delivering a new integrated community service to local residents, which commenced in August 2013. The service aims to provide appropriate "joined up" care and support to people close to home. Staff are working in multi-disciplinary teams across organisation boundaries to:

- support people to have a planned and safe discharge from hospital
- support those who have urgent health and social care needs to remain at home or return home from A&E
- provide focused short-term community-based care to help people remain at home and improve their independence
- support people who are unable to be at home in short term residential settings, while they regain their independence
- provide specialist support to people who have had a stroke or have a neurological condition to remain independent in the home

Through these services, we are able to respond rapidly to prevent the need for admission to hospital or residential care and to proactively case manage older people with complex care needs, jointly with GP's and community health staff. Further, through effective use of reablement and rehabilitation, we can help ensure that people are as independent as possible and able to achieve the best quality of life.

Improving Primary Care

General Practices have the key role in delivering primary care in Bexley. Following the recent NHS changes, NHS England is now responsible for commissioning all GP services in England, and for overseeing their quality and safety. NHS England has said that all GP services are facing a range of pressures, including: an ageing population with more complex needs; financial challenge; growing dissatisfaction with access to services; persistent inequalities in access and quality; and recruitment and retention issues around staff

To enable general practice to play an even stronger role in out of hospital services and delivering better health outcomes, NHS England has set out a range of objectives for primary care. These are:

- Proactive co-ordination of care, particularly for people with long term conditions and more complex health and care problems.
- Holistic care: addressing people's physical health needs, mental health needs and social care needs in the round.
- Ensuring fast responsive access to care and preventing avoidable emergency admissions and A+E attendances
- Preventing ill health , ensuring more timely diagnosis of ill health and supporting wider action to improve community health and wellbeing
- Involving patients and carers more fully in managing their own health and care
- Ensuring consistently high quality of care: effectiveness safety and patient experience

The Bexley Health and Wellbeing Board will work with Primary Care services in the borough to help them to meet these objectives, and will oversee progress towards them. This will include reviewing satisfaction with access to GPs to determine the degree to which this is a problem for local residents. New ways for people to access GP support will also be considered, including a telephone consultancy service.

Prevention

Demand for health and social care services is continuing to increase nationally. Population changes mean there are now more older and disabled people needing our support or care at a time when there are reduced resources across the health and social care system. The costs of treating chronic conditions in people of all ages also continues to increase. Investment in prevention is one of the most cost effective ways of reducing the burden of chronic disease and related health and social care costs. To ensure we make best use of the resources available to us we will need to invest in preventing ill health amongst the local population, so that where possible, we can avoid more costly acute medical interventions such as hospital admittance and surgery.

Wider prevention initiatives involve proactive approaches to keeping people well. Examples include investing in leisure and exercise opportunities to help people maintain a healthy weight, to avoid the costs (financial and personal) of interventions such as bariatric surgery.
We already invest in a range of preventative programmes, from various school-based programmes and health trainers to sexual health promotion. In addition we have a range of programmes for early detection of risk factors and chronic diseases such as the NHS health checks programme and chlamydia screening. We are developing other early intervention approaches, such as the Family Nurse Partnership Programme jointly with Bromley.

The Council and NHS Bexley CCG are also investing in a range of prevention and early intervention projects which are being delivered in partnership with the Voluntary and Community Sector. The projects support older people, people with learning or physical disabilities, people living with mental health needs, and carers. They aim to provide timely support to prevent people's needs from escalating or to help them to recover, following a period of illness or injury. In addition, the projects help to ensure that people have a positive experience of care and can benefit from a better quality of life.

When commissioning services, or redesigning care pathways, Health and Wellbeing Board partners will aim to refocus resources on prevention measures wherever possible, so that we are more effective at helping people keep well, rather than reactively treating them when they become ill. By supporting people in this way, we aim to improve the overall quality of life and wellbeing of the residents of Bexley.

Next Steps

Whilst the strategy sets out the broad areas of action, further work will be required to deliver the outcomes we need. Our approach will be:

- To develop detailed plans for the delivery of each priority – so that we know who is responsible for what.
- The Executive Group of the Health and Wellbeing Board will oversee the delivery of the action plans – to ensure actions are on track.
- The Bexley Health and Wellbeing Board will receive reports on the progress of each priority – to share what has worked well, what needs to be developed, and explore next steps.
- Although this is a three year strategy, it will be subject to a short review and revision after one year – to reflect the new evidence base emerging from the 2013/14 Joint Strategic Needs Assessment, which is currently under development.
- Progress with all of the above will be reported to the Health and Wellbeing Board.

The Bexley Health and Wellbeing Strategy is a joint strategy produced on behalf of the Bexley Health and Wellbeing Board and published by the London Borough of Bexley.

If you would like to know more about the Bexley Health and Well-being Board, or would like either a translation of this document or the information in a different format, please call our Customer Contact Centre on 020 8303 7777 and press 0.

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