Sutton Health and Care Plan

Our Health and Wellbeing Strategy for Sutton

March 2022

Acknowledgements

We would like to thank residents and communities of Sutton, our partners, staff and other stakeholders who were instrumental in the successful development of this Plan through their participation and feedback. We are very grateful for your support.

Recognition also goes to the Sutton Health Champions who have been influential in the delivery of the local COVID-19 vaccination programme.

Contact lola.triumph@swlondon.nhs.uk for more information about the Sutton Health and Care Plan

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Sutton System Partners

Foreword

We are delighted to welcome you to the refresh of the Sutton Health and Care Plan 2019 - 2024, which sets out our vision to sustain and develop good quality of life, access to decent jobs and services, and strong communities that we know are Sutton's strengths. We also want to ensure that these benefits are shared by everyone in our community, tackling the inequalities experienced by some of our residents

These are unprecedented times. Sutton residents and communities told us that the pandemic has negatively impacted their physical and mental health. We know that people living in certain parts of Sutton were disproportionately affected by the pandemic. These are also areas where there is low vaccine uptake when compared to the rest of Sutton.

Our plan has considered local population data and what local residents, health and care professionals and partners have said about what matters to them. We are committed to the central principle and approach that enables people to play an active role in maintaining their own wellbeing as part of a community.

We know we need to see a move towards preventative, proactive and reactive health and care in Sutton, as supported by the NHS Long Term Plan.

We are confident that by harnessing the assets and strengths of local communities and with the support of our health and wellbeing partners we will develop a whole system approach to improving poor health and reducing health inequalities

This will require integration across the entire health and care system, and as leaders in Sutton we are committed to this ambition and making this real for local people.

Dr Dino Pardhanani, GP and Chair, Sutton Integrated Care Partnership Board

Councillor Ruth Dombey, Leader of Sutton Council

Executive Summary

The Sutton Health and Care Plan which is an integral part of the “Ambitious for Sutton” Plan, is our Place strategy for working together to make system decisions on care that is ‘best for people’ based on the best use of the ‘Sutton £ (pound)’.

This plan marks a new chapter for the Sutton health and care partnership, setting out our commitment, ambitions, and priorities to reflect what local residents, communities and stakeholder have told us about their health and care needs.

The refresh of the 2019 Sutton Health and Care Plan is being developed within the context of the global COVID-19 pandemic that is affecting every area of our lives, increased pressure on NHS and social care services, new government policies regarding establishment of Integrated Care Systems and financial constraint within the public sector.

Our partnership has a strong track record of working together and we have made progress in improving the health of our population since we came together in 2017. During the COVID-19 pandemic, partners agreed to come together as providers and commissioners to form a single decision-making group to respond to the crisis. The strength of the local partnership has been demonstrated through the enormous efforts to protect NHS services, support residents, businesses and shield the most vulnerable in local communities.

Our extensive achievements since the publication of the 2019 plan are documented in the plan. Some examples are outlined below:

- We have improved the way we engage with communities and local residents to ensure meaningful and in-depth conversations. The delivery of COVID-19 vaccination programme led to strong engagement with Sutton communities. As a system, we spoke to over 600 people and reached over 5,000 through social media. Through the efforts of the 67 Sutton Health Champions (local councillors, housing and resident associations and local volunteers), for example, the *St Helier remains open* campaign in October 2020 reached over 89,000 residents within three hours of posting on social media.

- Sutton is in a much better position now than it was in early 2019 to describe the GP practice clusters with neighbourhood populations of 30,000 to 50,000 that are known as primary care networks (PCNs). There are four PCNs in Sutton - Central Sutton PCN, Cheam and South Sutton PCN, Carshalton PCN and Wallington PCN. The integrated working arrangement between community, charities, voluntary sector organisations and PCNs is the building block for future implementation of population health interventions at neighbourhood level.

- Over the last 12 months, partners have been working tirelessly to strengthen the support that is available to our most vulnerable local residents. The establishment of the four PCN Community Response Teams during the COVID-19 pandemic to support the most vulnerable residents and their families have evolved into the PCN led Sutton Community Virtual Ward which has the capacity to care for 100 patients at any one time.

- Sutton is the pilot site for the South West London Health and Care Partnership (SWL/HCP) NHS England/Optum Population Health Management programme. Locally there are emerging models of care in diabetes, hypertension, musculoskeletal osteoarthritis and obesity.

- Sutton Council, NHS Sutton and Sutton Health and Care Community Health Service Integrated Discharge to Assess delivery model has led to reductions in hospital admissions for over 65 year olds, reduced length of stay and achievement of home first by default for hospital discharges

This refreshed plan builds on our successes and takes a fresh look at how we can continue to deliver the best care for our residents. It provides the opportunity to refresh the priorities that were agreed in 2019 and consider our approach to working with our local population to start well, live well and age well. Examples of good practice that have been included in this plan celebrates our achievements and the strength of our local partnership without underestimating the long road to recovery and the long term effort that is needed to address health inequalities in Sutton.

We have difficult decisions to make if we want to ensure that we continue to deliver clinically safe, cost effective and high quality care to our residents. Led by our clinicians we will work as a system, to reduce the duplication and variation in our services, and agree a joint strategy for developing integrated care through blended teams.

We are committed to engaging with local residents and our stakeholders to ensure the right decisions are made to meet the needs of all who live and work in Sutton.

Introduction

In April 2019, we published the Sutton Health and Care Plan to cover a five year period until 2024. The plan outlines our vision for health and care integration and the challenges that we will collectively address in the coming years. The plan sets out how Sutton will sustain and develop good quality of life, access to health and care services and strong communities that we know are Sutton's strengths.

Our vision remains the same

We want to sustain and develop the good quality of life, access to decent jobs and services, and strong communities that we know are Sutton's strengths. We also want to ensure that these benefits are shared by everyone in our community, tackling the inequalities experienced by some of our residents

Our principles remain the same

We continue to aspire to achieve transformational change by following our partnership principles:

- A commitment to delivery of system outcomes through working in partnership;
- A commitment to transparency, honesty, collaboration, innovation and mutual support, developing a culture of trust;
- Always demonstrating the service user's best interests are at the heart of our activities;
- A commitment to work together and to make system decisions on a 'best for people' basis demonstrating best use of the 'Sutton £ (pound)';
- A commitment to take collective action and develop a partnership that increases the sustainability of the system;
- A commitment to establish an integrated collaborative team environment to encourage open, honest and efficient sharing of information; and
- A commitment to use our workforce differently to give us enough capacity in community, primary, social care and mental health services to ensure people can be cared for closer to home promoting self-care where this can be achieved.

Our local partnership has changed and now includes the four Sutton PCNs and unpaid carers.

The local health and care partners are:

- Community Action Sutton
- Community and voluntary sector partners including Age UK Sutton, Sutton Carers Centre and Sutton Parents Forum
- Epsom and St Helier University Hospitals NHS Trust
- Healthwatch Sutton
- London Borough of Sutton (Public Health, Adult Social Care and Children's Services)
- NHS Sutton (part of NHS South West London Clinical Commissioning Group)
- South West London and St George's Mental Health NHS Trust
- Sutton Primary Care Networks (Cheam and South Sutton, Central Sutton, Carshalton and Wallington) under a single delivery vehicle.

- Sutton Health and Care Community Services Provider Alliance (hosted by Epsom and St Helier University Hospitals NHS Trust, London Borough of Sutton, South West London and St George's Mental Health NHS Trust and Sutton Primary Care Networks)
- Unpaid carers - we recognise unpaid family, friends and carers as partners in the delivery of health and social care.

Recognition also goes to our 67 Sutton Health Champions who have been instrumental in the delivery of the local COVID-19 vaccination programme

Our achievements in the last 18 months

We are incredibly proud of our achievements in the last 18 months particularly in the face of the COVID-19 pandemic which created unprecedented challenges and opportunities for Sutton system. Some examples have been highlighted below.

Children and Young People Mental Health

- We established the COVID-19 resource hub for help and support during the pandemic. The hub includes guidance and advice for children, young people, teachers and anyone supporting a child or young person in South West London. (https://swlondonccg.nhs.uk/your-health/mental-health/covid19-resource-hub/)
- We utilised the Wellbeing for Education Grant provided to Sutton Council to commission training on emotional wellbeing recovery to all schools in the borough.
- Cognus re-introduced the call back services for parents and schools who wish to speak with an educational psychologist, implemented virtual consultations for primary schools; special educational needs coordinators and teachers produced guides for parents for children with a broad range of needs and proactively contacted 1,800 Sutton families with an Education, Health and Care Plan
- We commissioned Kooth, an online counselling and emotional well-being platform for children and young people, accessible through mobile, tablet and desktop and free at the point of use
- During the COVID-19 pandemic the school nursing service established a telephone duty support line for any child, young person or parent who would like some advice and support.

Making a difference

The Wellbeing SPACE Perinatal Group

The Wellbeing SPACE perinatal group which is co-delivered by the Sutton Uplift Wellbeing team in partnership with the Sutton Health Visiting Team has supported joint working and encouraged new mums to access Improving Access to Psychological Therapies (IAPT). Health visitors are offered supervision by the perinatal lead, and the group serves as a soft entry into IAPT for those mums that need evidence based support but may be reluctant to approach services without a trusting relationship in place. The Health Visiting Team provide interventions that support mum and baby bonding; the Wellbeing Team deliver interventions that support perinatal wellbeing and offer therapy support where needed. The group is popular, and the Health Visiting Team have fed back that their patients are now much more open to being referred to IAPT than previously. Phase 2 is about to be launched as a low intensity post-natal depression group and all elements will be evaluated.

Adult Mental Health

- Sutton is the South West London Health and Care Partnership pilot site for transformation of community services for people with serious mental health illness
- During the pandemic, we trained volunteers and non-clinical staff to act as additional support workers on wards (COVID-19 restrictions permitting)
- We implemented digital delivery and platforms to support service users and carers.
- We supported mental health care homes with infection control training and Personal Protection Equipment provision
- We launched the Sutton Crisis Café on 2 August 2021. This is for people over 18 years of age in Sutton who feel they are heading into a mental health crisis and want some support to keep themselves well, or for those who feel they have been struggling with their mental health. The service is open 6.30 - 11.00 pm, 7 days a week, 365 days a year and is provided by Sutton Mental Health Foundation

> *"You are treated as a person and not a problem"*
>
> **Gavin Glover, Person with Lived Experience, Peer Mentor, Sutton Mental Health Foundation**

- We developed the Orchid mental health assessment unit and subsequently the Coral Crisis Hub to provide emergency mental health support outside of accident and emergency – reducing footfall in acute hospital and supporting infection control.

Making a difference

Orchid Mental Health Assessment Unit – Accident and Emergency Diversion Pathway

Male patient, aged 78 presented to St George's Accident and Emergency Department in July 2020 with significant anxiety and thoughts of self-harm and believing himself to have been diagnosed with COVID-19. He was redirected to Orchid accident and emergency diversion pathway and assessed by the service and referred for a follow up by Sutton Older People's Community Mental Health Team.

Under the care of the Community Mental Health Team, he was allocated a care coordinator and at the outset of his care and treatment was provided with additional support by the Intensive Care Support Team. There was a focus on anxiety management and coping skills. In addition, the patient was seen by a psychiatrist and prescribed an anti-depressant with further careful consideration given to additional pharmacological treatment. As he improved the patient received additional support from the team's Recovery Support Worker under the supervision of the care coordinator. Medication compliance and response was overseen by the care coordinator. The patient was also in receipt of out of hours support from the Mental Health Support Line. The patient has made a recovery and has been discharged from secondary care services to primary care. He is able to travel around the UK and has been on holiday to Norfolk and been visiting his son in Birmingham.

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Children and Young People

- Young Voices and their impact:
    - Helped inform design of new hospital wards for young people, through consultation in schools
    - Wellbeing packs for young people across the borough during lockdown
    - Co-designed a survey for 16-18s on wellbeing, 488 responses (Sept - Oct 21)
    - Joined the Children's Delivery Board to share views and progress in their work
    - Led a workshop for system leaders in Oct 2021 to look at wellbeing for children and young people in Sutton
- NHS SWL CCG, Children's Service and Public Health joint funded a parenting role to respond to need in Sutton
- Universal Parenting offer is available in Sutton
- Practice networks taking place to build trust and relationship across the system for children. Bringing together teaching staff, health staff, early intervention social care, health visitors and school nurses etc.
- Adapted to needs throughout the year by making services more accessible - providing spaces for children with Special Education Needs and Disability in children's centres during lockdown.
- We are pooling information and sharing via schools so every family can know what support is available to them during COVID-19, throughout winter and summer periods

Adults with Learning Disabilities

- More adults with learning disabilities are now in employment opportunities (including volunteering, internships, apprenticeships and paid employment).
- Almost 78% of adults with learning disabilities are living in their own home or with family. This is an increase from 2016/17 when the figure was 71%.
- There are now fewer inpatients with learning disabilities going into specialist hospitals and mental health units.
- We have reduced the number of patients in specialist hospitals under the Transforming Care Programme, particularly patients that have been admitted to long-stay units
- We have reduced the numbers of patients with a learning disability placed in specialist learning disability hospitals or mental health units
- A GP Clinical Lead has been appointed to lead on learning disabilities health transformation

Health and Care Integration

- The pandemic has created significant pressures and demand for primary care, community services and St Helier Hospital. The additional South West London Ageing Well Programme investment in primary care and community services has enabled the provision of community two hour urgent response for people living in their own home and **one local single point of access** ensuring a **'no wrong-door'** ethos and ability for people known to services to self-refer.

- Sutton Council Adult Social Care, NHS Sutton Continuing Health Care and Sutton Health and Care HomeFirst Services collaborated to establish the Epsom and St Helier University Hospitals NHS Trust discharge and assessment hub that supported over 250 patient discharges during a 6-week period to release over 100 hospital beds at the peak of the pandemic

Care Homes and Community Bed Based Care

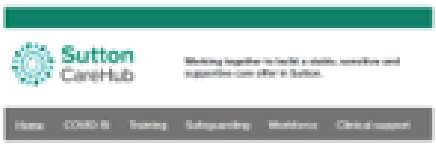
- Every Care Home has received face to face Infection Prevention Control Personal Protection Equipment training via the Train the Trainer Model. This covers 1,200 staff. Since August 2020, additional Infection Prevention Control training has been delivered to domiciliary care providers, Supported Living, day centres and care homes requiring refresher course

- Members of the Sutton Bed Based Board developed the Alert Response and Plan Quality Assurance framework to support control of COVID - 19 transmission in care homes. Lessons from the implementation of the framework will inform the programme of the work of the joint Sutton Council and NHS Sutton care homes and bed based provision group which was established during the COVID-19 pandemic to support care homes

- All Sutton care home staff have received baseline training on RESTORE2. Sutton is leading the way within the South West London Health and Care Partnership.

- We have established regular care home support Q&A live sessions providing advice and guidance, sharing learning between homes and learning from the experience of care homes to shape the support offer

- Sutton Council has launched a new Sutton Care Hub with latest guidance and support for Care Providers in Sutton



End of Life Care

- We launched Sutton's Joint End of Life Care Strategy for Adults and Young People 2020-2023 - 'living my best life to the end'. The development of the strategy's priorities and implementation plan was created using the Quality Improvement (QI) methodology.

- The Palliative Care Coordination Hub launched in April 2020 through an innovative partnership with Social Finance during the first wave of the COVID-19 epidemic and

national lockdown. The Palliative Care Coordination Hub supports our approach to the delivery of end of life services for patients during the last 12 months of their life.

Population Health and Reducing Health Inequalities

- **Community engagement and asset building -** The COVID-19 pandemic has forced us to rethink our strategy for engaging local communities especially where there has been low vaccine uptake and vulnerable groups such as people with learning disabilities, mental health issues, the homeless and Travellers and Gypsy communities. Our community asset programme has been enriched through strong engagement with Sutton communities and Sutton Health Champions. The listening and health assurance events provided the forum for Primary Care Networks Clinical Leadership, Sutton Council Public Health, voluntary sector organisations, Epsom and St Helier University Hospitals NHS Trust and the NHS South West London Clinical Commissioning Group (Sutton) to cascade key messages about COVID-19.

- **Emerging models of care for population health.** Sutton Place has been selected to participate in the NHS England/Optum Population Health Management programme. The goal is to support one Place within an Integrated Care System (ICS) to demonstrate how whole population predictive analytics can support collaboration that will result in better outcomes and value. Our understanding of population segmentation is evolving into better understanding of geographical needs, groups of people experiencing broadly the same conditions or at the same stage of life. The model for understanding the population in-depth is still in development. For example, the Carshalton PCN population health data indicated that 2,930 patients registered with Carshalton PCN are diagnosed with Type 2 diabetes and that the PCN has the highest diabetic population in Sutton. Engagement with clinicians, registered patients and, community stakeholders as well as personal interviews with patients, already diagnosed with Type 2 diabetes, provided insight into why existing diabetes education programmes were not being taken up. Patients described some of the factors affecting the ability to control their diabetes as income, caring responsibilities and motivation. Feedback from engagement has informed the development of a Carshalton Diabetes model design and population segmentation (Fig.1) which will be tested with patients. The plan is to spread the model to the remaining Sutton PCNs from April 2022 onwards.

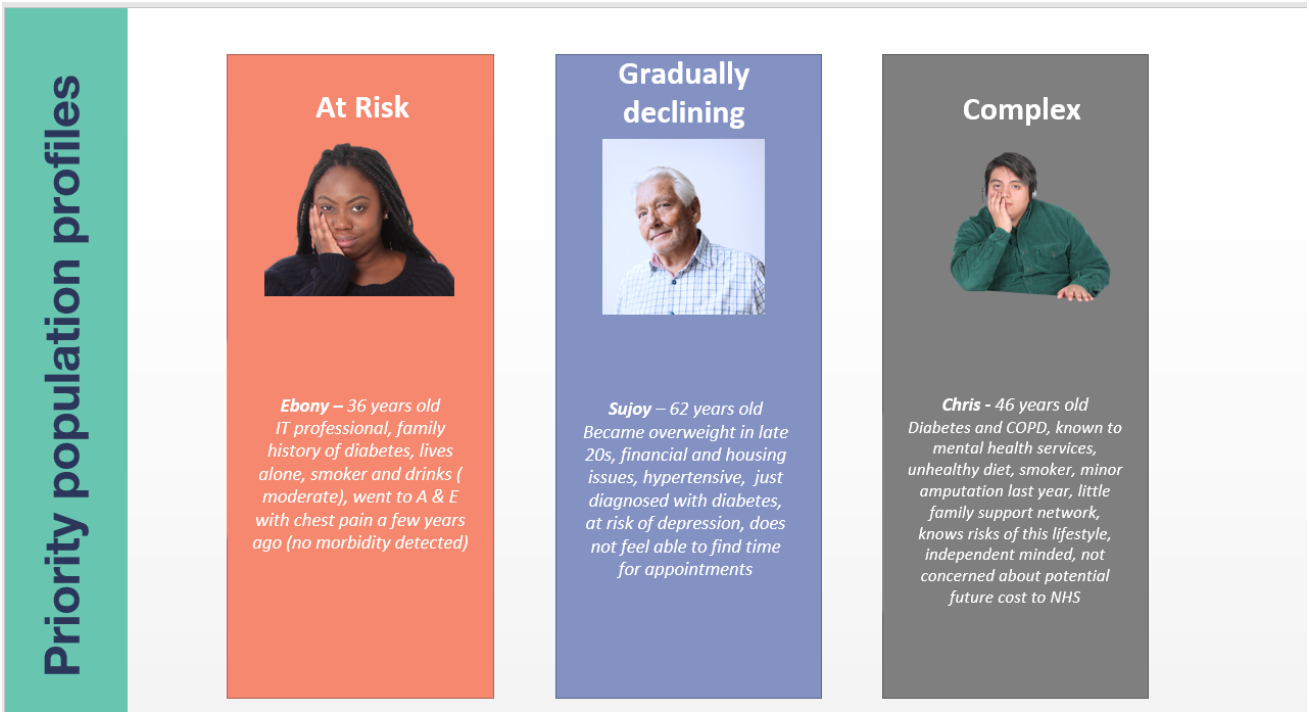
- **Volunteering and Peer Support -** We recognise the critical role of grassroot organisations, charities and voluntary sector organisations and have worked with them to develop targeted local responses such as peer support model that is being delivered by **Diabetes UK Carshalton Diabetes Group** and the **Sutton Crisis Café by the Sutton Mental Health Foundation**

Making a difference

Peer Led Support for People with Type 2 Diabetes in Carshalton, Sutton

The Diabetes UK Carshalton Group aims to provide support, companionship, education and information for people living with diabetes and their carers. The Diabetes UK Carshalton Group played a key role in the development of the diabetes model of care for people living in Carshalton area. The Group will provide a peer led support as a result of collaboration with local Carshalton GP Practices, NHS Sutton, London Borough of Sutton Public Health, Healthwatch Sutton and, local community organisations.

Figure 1: Carshalton PCN Diabetes Population Segmentation



Sutton PCN Led Community Virtual Ward is a local example of innovative practice that is transforming patient care in Sutton

Making a difference

Sutton PCN led Community Virtual Ward

(partnership between Sutton Primary Care Networks, Age UK Sutton, Sutton Council Adult Social Care, Sutton Health and Care Community Services and Epsom & St Helier University Hospitals NHS Trust)

The Sutton PCN led Community Virtual Ward was established on 2nd February 2021 as part of the NHS response to COVID-19. The virtual ward supported safe and earlier discharge of coronavirus patients from St Helier Hospital. Over 200 patients have been referred to the virtual ward since it opened in February 2021.**The virtual ward has the capacity to support 100 patients at any one time.**

The virtual ward service offer includes three times per week virtual ward round, pulse oximetry, wellbeing checks (Day 2 and 7 following discharge), management of complex cases through PCN aligned Community Response Teams (multidisciplinary team (MDT). The virtual ward has transitioned to include long term conditions such as heart failure and Chronic Obstructive Pulmonary Disease (COPD) and frailty with the support of PCN Clinical Directors, frailty and respiratory consultants from Epsom & St Helier University Hospitals NHS Trust, Social Prescribing Link Workers, Medicines Optimisation Team, Adult Social Care, MDT Clinicians and MDT Coordinators. Patients are able to self-monitor their vital signs using the VCARE remote monitoring kit.

The virtual ward is supported by an established step up hospital prevention pathway. The step down hospital discharge pathway **will support winter planning and hospital discharges.**

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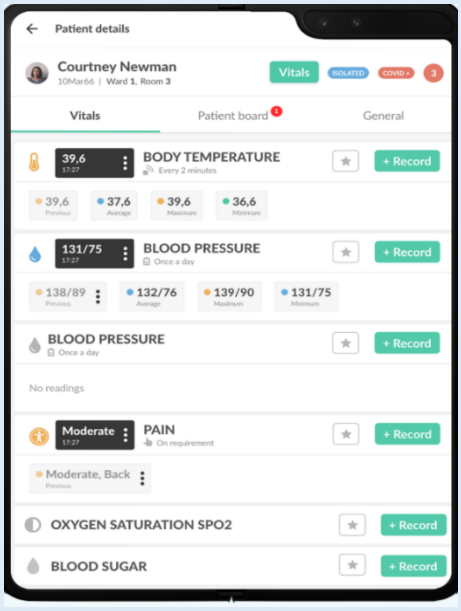
Sutton PCNs in partnership with Ardens Healthcare Informatics developed the first Ardens Virtual Ward Template for GP EMIS digital clinical system. The template will be available to GP Practices /users of EMIS in England.

160 Virtual Ward VCARE Remote Monitoring Kits to support our 2 hour community based urgent response, learning disability and mental health care homes



Photograph of a real virtual ward patient using the VCARE remote monitoring kit (used with permission)

National Context: Overview of New Policy Development

This section of the plan provides an overview of national policies that have been issued since the publication of the Sutton Health and Care Plan in 2019. These policies are shaping the local priorities and future work programme of new Integrated Care Systems and development of the Sutton Integrated Care Partnership.

Thriving places

Guidance on the development of place-based partnerships as part of statutory integrated care systems

https://www.england.nhs.uk/wp-content/uploads/2021/06/B0660-ics-implementation-guidance-on-thriving-places.pdf

Integrated Care Systems: design framework

Version 1, June 2021

Content referring to new statutory arrangements and duties, and/or which is dependent on the implementation of such arrangements and duties, is subject to legislation and its parliamentary process.

https://www.england.nhs.uk/wp-content/uploads/2021/06/B0642-ics-design-framework-june-2021.pdf

2021/22 priorities and operational planning guidance

25 March 2021

The 2021/22 priorities and operational planning guidance sets the priorities for the year ahead, against a backdrop of the challenge to restore services, meet new care demands and reduce the care back logs that are a direct consequence of the pandemic, whilst supporting staff recovery and taking further steps to address inequalities in access, experience and outcomes

Health and Care Bill introduced to Parliament

New proposals to build a modern health and care system that delivers better care for our communities are being introduced in Parliament today

The Health and Care Bill builds on the proposals for legislative change set out by NHS England in its Long Term Plan, while also incorporating valuable lessons learnt from the pandemic that will benefit both staff and patients

The government is committed to delivering world class care for patients and this Bill will help deliver that by building on the NHS own proposals for reform to make it less bureaucratic, more accountable and more integrated in the wake of COVID-19

Integrating care

Next steps to building strong and effective integrated care systems across England

This builds on the route map set out in the NHS Long Term Plan, for health and care joined up locally around people's needs. It signals a renewed ambition for how we can support greater collaboration between partners in health and care systems to help accelerate progress in meeting our most critical health and care challenges

https://www.england.nhs.uk/wp-content/uploads/2021/01/integrating-care-next-steps-to-building-strong-and-effective-integrated-

Implementing phase 3 of the NHS response to the COVID-19 pandemic

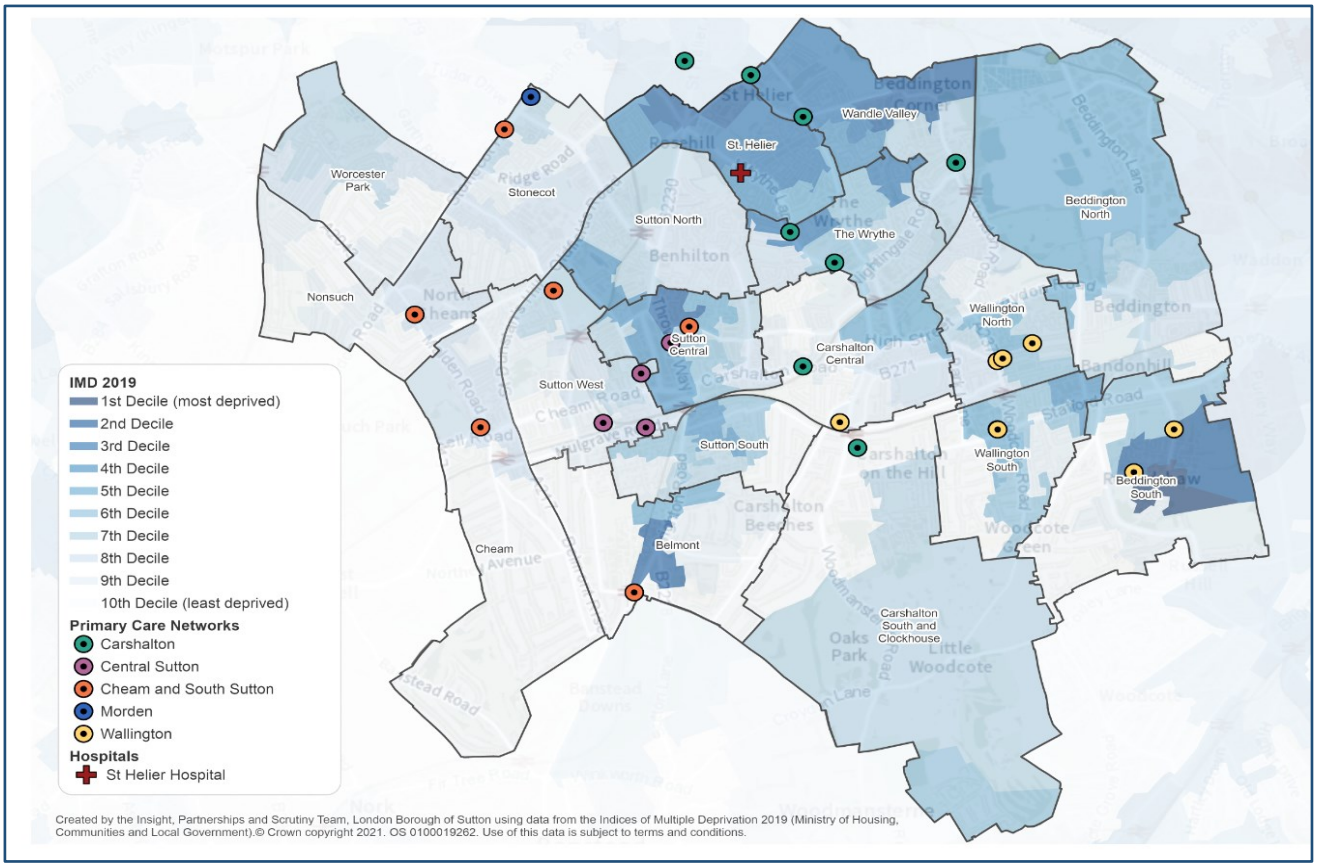
7 August 2020*

Document asking partners to work collaboratively locally to tackle health inequalities

https://www.england.nhs.uk/wp-content/uploads/2020/08/C0716_Implementing-phase-3-v1.1.pdf

Sutton Context

About Sutton



Source: Sutton Council

- 1 local authority
- Around 206,000 people reside within the geographical boundary of the London Borough of Sutton
- 23 GP Practices (organised across 4 primary care network population clusters of 30,000 to 50,000)
- Around 207,000 patients are registered with Sutton GP Practices
- 1 acute hospital
- 1 acute mental health trust covering Sutton and other south west London Boroughs
- 1 community health service provider
- 267 charities and voluntary sector organisations delivering a range of services
- 78 care homes in Sutton. 28 for older people, 43 for people with learning disabilities and seven for people with mental health

Demographics

Sutton has become more ethnically diverse over the last decade, with White 79%, 12% of people from Asian or Asian British ethnic groups and 9% black or black British from other ethnic group.

Sutton's population is forecast to grow to 213,805 by 2030. This increase is higher than the average across England for older people aged 60 and over. As the population ages and long term conditions increase in prevalence, services are being asked to do more with less, making the economy unsustainable in its present form. To ensure the Sutton economy can effectively support the population in the future, partners are working together to transform the way services are delivered.

Life expectancy

Sutton has better health outcomes compared to national averages with life expectancy and healthy life expectancy higher than the national and London averages, however **people living in our deprived areas are doing worse with higher rates of preventative deaths than England average.** The health needs of residents range from complex and linked challenges, such as the increase in people living with chronic illness and long-term illness linked to our ageing society, and growing health inequalities. Focused work is required to address inequalities based around income, employment, health, education, housing, crime and the environment. It is the audacious goal of the Sutton Integrated Care Partnership to increase the life expectancy of the residents of St Helier and Wandle Valley in line with the rest of Sutton.

St Helier	Wandle Valley	Beddington South	Sutton
Life expectancy 👴 **79.4** 👩 **82.9** **20%**more preventable deaths than England average.	Life expectancy 👴 **79.5** 👩 **81.3** **5%** more preventable deaths than England average	Life expectancy 👴 **81.7** 👩 **82.9** **2%** more preventable deaths than England average	Life expectancy 👴 **80.8** 👩 **84.2** **20% fewer** preventable deaths than England average

Preventable Deaths

Mortality rate from causes considered preventable is particularly high for men and collectively high for all persons when compared with London for cancer, liver disease and respiratory disease

We know that too many people are unhappy. A survey measuring individual wellbeing reported that people aged 16 + years self-reported low happiness and high anxiety when compared with London and England

Many people including children have poor mental health and related problems. Suicide rate is on the upward trend for both male and female aged 10 years and over**.** Emergency hospital admission episodes for intentional self-harm and alcohol related conditions for all ages is high when compared to the average across London and lower than England.

The Health and Care Challenges for Sutton

National Must dos

Integrating care: next steps to building strong and effective integrated care systems across England (the White Paper) describes the function of integrated care systems around four primary purposes:

- improving population health and healthcare;
- tackling unequal outcomes and access;
- enhancing productivity and value for money; and
- helping the NHS to support broader social and economic development

The NHS Operational Planning Guidance for 2022/23 published in December 2021 sets out priorities for the year against the backdrop to restore services, meet new care demands and reduce the back logs that are a direct consequence of the pandemic, whilst supporting staff recovery and taking further steps to address inequalities in access, experience and outcomes. The priorities include:

- workforce investment, including “strengthening the compassionate and inclusive culture needed to deliver outstanding care”.
- responding to Covid-19.
- Delivering “significantly more elective care to tackle the elective backlog”.
- Improving “the responsiveness of urgent and emergency care and community care capacity.”
- increasing timely access to primary care, “maximising the impact of the investment in primary medical care and primary care networks”.
- maintaining “continued growth in mental health investment to transform and expand community health services and improve access”.
- using data and analytics to “redesign care pathways and measure outcomes with a focus on improving access and health equity for underserved communities”.
- achieving “a core level of digitisation in every service across systems”.
- returning to and better “prepandemic levels of productivity”.
- establishing integrated care boards and collaborative system working, and “working together with local authorities and other partners across their ICS to develop a five-year strategic plan for their system and places”.

The Sutton System recognises that local response to national priorities as part of the wider South West London Health and Care Partnership require innovation, joined up working and strong partnership.

The challenges identified in the 2019 health and care plan broadly remain the same and, in some cases, have been worsen by the COVID-19 pandemic.

Poor physical and mental health and persisting health inequalities in areas of deprivation, increased demand for primary care, community and acute hospital services and finally financial and workforce constraints as a result of COVID-19 pandemic. Local population insight data highlighted that people with cardiovascular disease such as hypertension, high BMI, over 70 year olds were more likely to be hospitalised with COVID or engaged with NHS

111. In most cases, these individuals were already known to mental health and community services. In addition, the Kings Fund Independent Review of Health Inequalities in Sutton and Merton (2021)[i] commissioned by NHS South West London Clinical Commissioning Group highlighted the following:

Obesity

- Adult obesity has increased in Sutton. People in Sutton are overweight and obese with levels higher than London average and about in line with the national average. This pattern of adult obesity is mirrored in obesity in early pregnancy in 2018/19 higher than London
- Childhood obesity (Reception year and Year 6) is similar to or below the England as well as borough level average in several wards of Sutton. In several wards, obesity in Reception year is similar to or below the average for England and several wards, show a downward trend. Obesity levels are higher in some northern wards (including St Helier, Beddington South, The Wrythe and Wandle Valley) and some wards such as Beddington North, Cheam, Carshalton Central, Beddington South, The Wrythe and Wandle Valley) show a rising trend in recent years

Diabetes

- Both type 1 and type 2 diabetes have been rising in prevalence in Sutton possibly reflecting higher adult obesity levels in Sutton. More people with type 2 diabetes have a minority ethnic background

"*It's changed our lives completely, self-isolation especially. Our physical and mental health, as well as our social lives have all been impacted. It's made us realise that we should appreciate the small things, and not take things for granted (especially loo roll!))*"

Source: Healthwatch Sutton, COVID-19 Survey

Impact of COVID-19 on mental health

Mental health has been significantly impacted with high referrals to psychological therapy services and presentation at accident and emergency department.

One of our local stakeholders reported that '*many people are facing a cost of living crisis - the £20.00 per week reduction in Universal Credit which has now come into force, fuel prices are rising, and food price inflation is high. These issues have obvious implications for physical health, mental health and wellbeing'*.

The Kings Fund Independent Review of Health Inequalities in Sutton (2021)[1] referenced self-reported data from discussion with stakeholders, patients' resident's weekly situation reports between health and voluntary, community and social enterprise providers indicate an increase in poor mental health for at least one of the following groups (with some noting an overlap of such characteristics):

- older people
- young people
- pregnant women
- carers
- people from minority ethnic backgrounds

[1] The Kings Fund Independent Review of Health Inequalities in Merton and Sutton: a focused review of health inequalities and mitigation activities related to the Improving Healthcare Together programme

Stakeholders alluded to increases in anxiety, distress, suicidal ideation, people being sectioned and rates of autism and attention deficit hyperactivity disorder diagnoses, as well as a general increase in loneliness being reported across the population. Not only were new conditions being reported but there was also a worsening of existing conditions, with the pandemic directly or indirectly cited as a contributing factor.

For older people, worsening mental health was speculated to be in part due to a perception that they were being blamed for the need for a national lockdown, as it is generally accepted that Covid-19 outcomes are worse for this group. Similarly, it was suggested that worsening mental health in children was linked to restricted activities impacting self-esteem as well as school-readiness.

For those living in deprived areas in Sutton, it was suggested that wider determinants, such as crowded housing, debt and joblessness among others, were compounding increasing levels of poor mental health.

"*In the first two months of the first lockdown, 1,277 named, individual Sutton residents contacted us. 48% of these residents had not previously contacted us, but needed our advice due to sudden reductions in income or loss of employment etc. We had 2,247 visitors to the Citizens Advice Sutton website in this period and over 9,000 unique visitors to our website over the year. The numbers of* ***clients contacting us in distress and possibly suicidal increased and we arranged suicide awareness training for our staff and volunteer****s.*

We continued to provide a casework service for clients, with clients sharing documents with us by email and WhatsApp. We set up systems to provide support and supervision to volunteer advisers who were working from their homes"

Steve Triner, CEO, Citizens Advice Bureau. Source: CAB Annual Report

Impact of COVID-19 on black, Asian and minority ethnic group

The Public Health England Beyond the data: understanding the impact of COVID-19 on black, Asian and minority ethnic (BAME) groups (2020)[2] report by Professor Kevin Fenton highlighted that the unequal impact of COVID-19 on BAME communities may be explained by a number of factors ranging from social and economic inequalities, racism, discrimination and stigma, occupational risk, inequalities in the prevalence of conditions that increase the severity of disease including obesity, diabetes, cardiovascular disease and asthma.

NHS South West London CCG (Sutton) ethnicity data for COVID related admission indicated that people with White ethnicity are likely to be admitted with COVID and that a higher percentage of Asian and black women with suspected COVID positive called NHS 111 during the pandemic. NHS 111 callers were likely to have been diagnosed with hypertension, respiratory disease, BMI 40+ and multiple long term conditions.

Increased demand for emergency services

The number of patients attending St Helier Hospital Accident and Emergency Department is not where we want it to be. We need to develop a whole system response to minimise the demand for emergency services through engagement with Sutton residents who themselves have a key role to play in the solution. The scale of both the challenge to improve the health of our population and create a sustainable system remain significant. We remain committed

[2] Beyond the Data: Understanding the Impact of COVID-19 on BAME Communities (publishing.service.gov.uk)

to the ambitions and principles, articulated in the original Plan. We recognise there is more to be done on our transformation journey. We are now turning our attention to developing population health strategy that is framed around engagement of people at neighbourhood level to support co-production, reach into deprived communities to ensure equality of engagement and access to services.

Reducing health inequalities

We know that reducing health inequalities is much more than health as 80% of wider determinants of health relates to social, economic factors and the crucial role of communities and only 20% of a person's health outcomes are attributed to the ability to access good quality health care. It is about jobs that local people can get, decent housing and preventing people becoming isolated, it follows that we also recognise that places and communities have the most critical role to play.

Due to COVID-19 there has been an increase in Sutton residents out of work and those who claimed benefits. between March 2020 to March 2021, the proportion claiming benefits rose from 2.4% to 5.8%. Data and stakeholder feedback that have been captured throughout this plan indicate that people who live in geographical areas of deprivation across Sutton are most likely to be significantly impacted by the COVID-19 pandemic.

The Index of Multiple Deprivation also highlight the following:

- Sutton is ranked 226th least deprived of 317 local authorities in England, and 30th least deprived of 33 London boroughs. One neighbourhood in Beddington South is within the most deprived 10% of England. The Indices of Multiple Deprivation are a measure of relative deprivation used to rank neighbourhoods across the UK
- Around 13 neighbourhoods (largely in St Helier, Wandle Valley and Beddington South) are within the most deprived 30% in England. By comparison, 21 neighbourhoods are in the least deprived 10% of England.
- Around 18,298 carers who live in Sutton can be found in the most deprived wards – St Helier, Wandle Valley and Wallington South.
- Beddington South scores highest for mood and anxiety with high rates of acute morbidity in Sutton Central (Figure 2). The Health Deprivation and Disability domain measures the risk of premature death and the impairment of quality of life through poor physical or mental health. The domain measures morbidity, disability and premature mortality but not aspects of behaviour or environment that may be predictive of future health deprivation. Lower Super Output Areas (LSOA) are small areas with average of 1,500 residents or 650 households.
- Residents living in Beddington South have seen some of the largest increases in health and disability since 2015 (Figure 3)

Figure 2: Health Deprivation and Disability

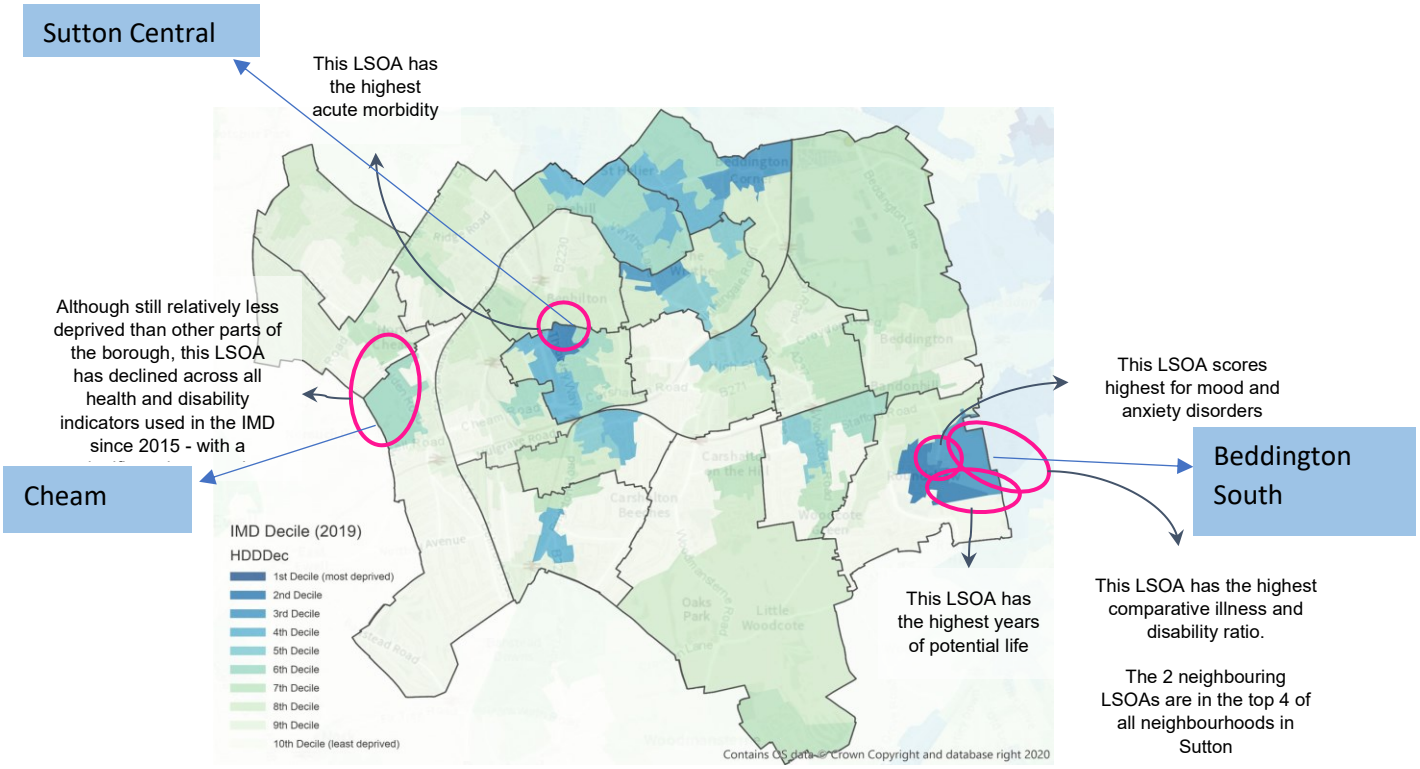
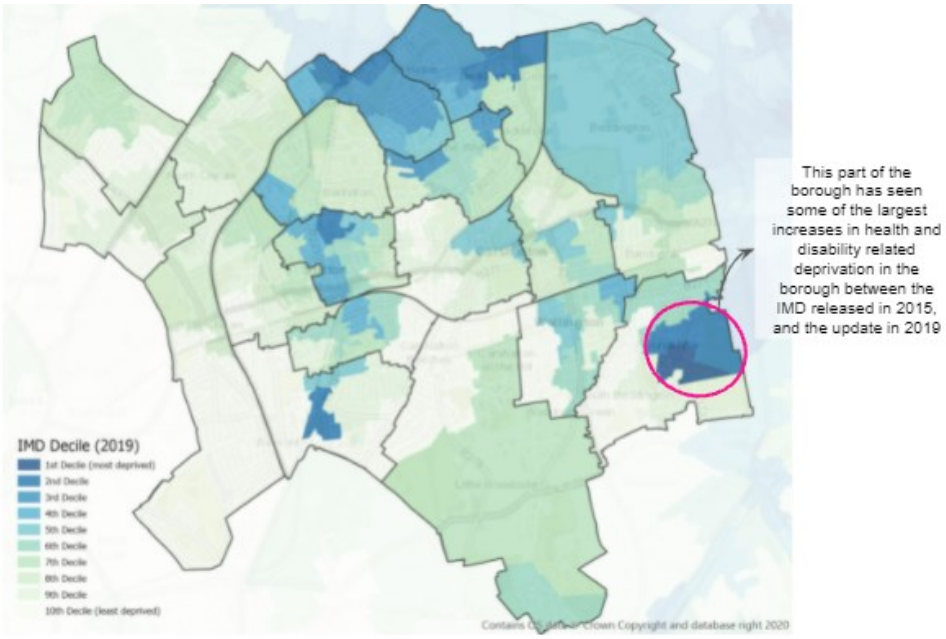


Figure 3: Health Inequalities: Indices of Multiple Deprivation



Source: Ministry of Housing, Communities & Local Government (2019). English indices of deprivation 2019.

Social and Community conditions - Sutton is 40% least at risk of being digitally excluded nationally. Data has been provided for St Helier, Wandle Valley and Beddington South as the three wards where there are higher levels of deprivation than elsewhere in the borough.

There is variation between wards: St Helier is broadly more at risk to experience social and community inequality than the rest of the borough. Although on the face of it, residents in Wandle Valley experience less inequality; Middle Layer Support Output level data built on minimum population of 5,000 for Wandle Valley shows an inequality even between two

parts of wards: the risk of digital exclusion in one part of Wandle Valley is in the 30% least at risk, whilst another part is within the 30% most at risk. Residents are also more at risk of loneliness.

Living and working conditions - In Sutton, 13% of all children aged 0-15 live in low income households below the poverty line. Data has been provided for St Helier, Wandle Valley and Beddington South as the three wards where there are higher levels of deprivation than elsewhere in the borough. Analysis of impact of deprivation on residents living in these areas suggest that the children and young people living in the most deprived areas may not have had the best start in life, and as a result, they are more likely to enter adulthood either having no qualifications or GCSEs.

The role of anchor organisations in Sutton

Anchor organisations are described as large organisations that are unlikely to relocate and have a significant stake in their local area. They have sizeable assets that can be used to support their local community's health and wellbeing and tackle health inequalities. Anchor institutions such as the local NHS and London Borough of Sutton are committed to partnering with communities by learning from and working with local community groups and organisations that can help these institutions gain insight into how they can contribute to the wider determinants of health – the social, economic and environmental conditions that shape good health.

London Borough of Sutton in particular has a crucial role as a 'place leader' in bringing the partnership together to identify and address these wider determinants and make Sutton an even better and healthier place to live for everyone. This work cuts across much of the Council's core business, but some specific recent examples include:

- the area renewal programme in St Helier, which focused on employment and skills and social wellbeing, alongside investment in physical regeneration
- the Affordable Housing Supply programme, which is underpinned by a focus on social value and the health and wellbeing benefits of housing
- the recent voluntary and community sector grant programmes (Recovery and Rebuild Funds) which focused specifically on targeting wider determinants of health such as social isolation and financial hardship.

The London Borough of Sutton and Epsom and St Helier University Hospitals NHS Trust have agreed to participate in the NHS England and DFN Project Search ambitious programme to support the NHS Learning Disability Employment Pledge to bring out more job opportunities for people with learning disabilities and autism aged 18 -25 year olds. St Helier Hospital will be one of 42 NHS Trusts participating in the programme. DFN Project Search will support London Borough of Sutton, Orchard Hill College and Epsom and St Helier University Hospitals NHS Trust to deliver work placements for young people at the St Helier Hospital site. Programme is planned to start in September 2022.

The work of the Sutton Housing Partnership (SHP) provides us with a local example of opportunities to integrate housing, health and wellbeing. SHP has moved away from a traditional social housing model to a model that focuses on the health and wellbeing of its tenants. This is an example of how Sutton Council is using the local democratic process to integrate civic functions such as housing, welfare, job creation with health and wellbeing.

Spotlight on the Sutton Housing Partnership

Sutton Housing Partnership (SHP) manages council housing stock on behalf of Sutton Council for circ. 7,500 Sutton residents (6,000 tenanted and 1,500 lease holders)

St Helier Community Food Shop

The St Helier Community Food Shop supports the distribution of surplus food. We work with supermarkets, Fareshare and the Felix Project in order to ensure that there is a regular supply of surplus food. In addition to supporting residents to access £15 worth of food for a £3 weekly subscription fee, the project aims to promote healthy eating on a budget and meal planning. The project also aims to support residents and families who have specific dietary needs. The objective in the long term is to set up a satellite shop around the Sutton/Belmont area.

Older People Health and Wellbeing Project

Pilot project for older residents - Around 2 years ago, SHP set up a pilot project for older residents based on health and wellbeing. Activities included drumming for therapy (Gary Mason Charity), chair yoga, soup club and craft activities. We produced a very basic 'patient activation measure' to allow us to monitor the benefits to residents. This was completed at the start and end of the project. Residents reported significant benefits including improved memory, coordination and mental health.

Community Employment Link Worker

SHP is currently recruiting for the role of Community Employment Link Worker although we have been developing an employment support service for some months now which includes working with Sutton College to offer bespoke courses for our residents. These courses include pre employment support, digital, Maths & English, first aid and health and wellbeing courses. The Community Employment Link Worker will initially be responsible for working with residents who requested employment support following our Covid-19 survey for residents but will also be working with marginalised and disadvantaged groups to support them in addressing barriers to employment and by providing a person centred 'hand holding' approach to support both skilled and unskilled residents in accessing employment. We are working with a range of partners to offer 'live' vacancies and are also working to ensure that both SHP & LBS housing contractors demonstrate social value during the procurement process to ensure that there is a direct benefit to local residents.

Partnership with Sutton Uplift

We are working with Sutton Uplift to attend community based events to offer 'taster sessions' to residents to encourage them to access the services of Uplift.

Project to help residents improve their nutrition

In terms of a focus on health, we have also secured £2k funding from Community Action Sutton to look at offering residents with long term health conditions greater support to encourage them to improve their nutrition as this may directly impact on their health. This is likely to link in with residents who are accessing the community food shop and through contact that our Housing Managers are having with residents.

What People Have Told Us

Background

The communication and engagement plan for this refresh will build on and consolidate feedback from interviews with 11 local leaders of grassroot organisations; extensive engagement with residents, professionals and various community groups in the last 12 months to ensure that local issues, concerns and understanding have been captured in our plans for improving health and care services.

In October 2020, our Sutton Community Health Champions reached at least **89,000** Sutton residents through social media (Facebook, WhatsApp and Twitter) within 3 hours of launching the St Helier Hospital **"St Helier remains open"** campaign on social media.

As a system, we spoke to over 600 people at 26 listening events, webinars and interviews led by NHS Sutton Engagement Team, with support of Sutton PCN Clinical Leaders, St Helier Hospital, Sutton Council and Community Health Champions to ensure that local residents have the correct information to make decisions about COVID-19 vaccination.

Further on how we engaged with local residents are outlined below:

- **Listening sessions** - we worked with voluntary sector to host community conversations to provide evidence about the vaccine, hear local stories and gather insight
- **COVID- 19 Vaccine Round table discussion with Elliot Colburn, MP streamlined live on Facebook.**
- **Webinar:** Sutton Council Leader led Council and NHS Sutton *Keep Sutton Safe webinar* COVID Q & A session for Sutton residents
- **Outreach approaches**: such as pop up clinics, door knocking, on-street engagement, text messaging, leafleting and other targeted communications, delivered as part of a wider programme of activities focused on increasing vaccination uptake and building COVID resilience in communities, helped to tackle vaccine hesitancy through "effective conversation

> **"**Although 22 people attended the session the video has already *been seen 3,100 times and reached over 5,000 people, which is phenomenal, so thank you for making it such a success!"* **Elliot Colburn, MP**

Sample feedback from surveys, Listening Events, photos and examples of COVID -19 targeted outreach and promotional materials are enclosed as an appendix.

Emerging themes from What People Have Told Us

Below we have illustrated the phrases, words and concerns that we heard most often from responses to the engagement (the size of the text indicates the number of responses giving this as a key priority).

People told us:

- That they are concerned about the impact of COVID-19 and recovery
- That they need support with mental health issues such as depression, isolation and anxiety
- About the myths circulating among the communities about the effectiveness and safety of the vaccine
- About their interest in seeing conversion of empty retail space to community projects
- That they are concerned about access to medical support, such as routine NHS appointments and face to face contact with GPs
- Lots of positive feedback and support for the model of engagement utilised during the COVID-19 listening events

The emerging themes incorporate feedback from Advocacy for All on the Learning Disability Strategy consultation; Healthwatch Surveys on COVID-19 Experience; The Stronger Sutton Conversation: Residents' Survey (findings relevant to the health and care plan) and COVID-19 Listening events. In addition, quotes and reflections from 11 local leaders of grassroot organisations who were interviewed as part of engagement for the Sutton Health and Care Plan have been reflected throughout this document.

Key engagement planned or already undertaken with local partners are:

- Sutton Integrated Care Partnership Board - 13th October 2021
- Sutton Voluntary Sector Forum – 10th November 2021
- Sutton Health and Wellbeing Board – 6th December 2021
- Sutton Plan Partnership Event – 1st February 2022
- Sutton Health and Wellbeing Board approval – 6th December 2022

There is a real commitment to engage residents and communities in Sutton on the health and care issues that matter to them. We will use the feedback received to start in-depth conversation with residents, communities and stakeholders on how best to partner with them as we work together to address the health and care challenges facing Sutton.

Addressing Sutton's health and care challenges

There is a real commitment to convert population insight and data into tangible actions. A central principle of our approach is people playing an active role in maintaining their own wellbeing as part of a community.

Ensuring a whole systems approach to improving poor health and reducing health inequalities by harnessing the assets and strengths of local communities.

In everything we do we believe in challenging the status quo to get the best out of the Sutton pound. We do this by making sure health and care in Sutton delivers what people have asked it to deliver through the shared vision and principles set out in the Sutton Plan and the commitment to deliver (the best) preventative, proactive and reactive health and care in Sutton

This plan has been developed with the aim of making sure that Sutton residents start well in life as children and young carers, live well as adults and age well with dignity. We will build on the collaboration, innovation and new ways of working that emerged during the COVID - 19 pandemic to support delivery of health and wellbeing outcomes for local residents.

This is a refreshed plan of action that aims to deliver the following health and care priorities over the next two years:

- Strengthening and partnering with communities of ethnicity, interest and geography through co-production of health and well-being solutions
- Tackling health inequalities and the social determinants of health in vulnerable groups such as people with a learning disability, adult and young carers; vulnerable migrants; Gypsy, Roma, Traveller and Lesbian, Gay, Bisexual and Transgender (LGBT) communities
- Improved health and wellbeing of the population especially in light of COVID-19 pandemic with particular focus on mental health, cardiovascular diseases, diabetes, musculoskeletal and obesity
- Community services and GP primary care networks neighbourhood teams to support proactive approach to managing population health needs at neighbourhood levels

To realise these aims, we will continue to evolve our health and care services to meet new patterns of care, demand, and opportunities from innovative practices and technologies.

The next sections of this document updates on programme of work that will deliver the priorities of the Sutton Health and Care Plan over the next two years.

Strengthening Communities

Community Voice
Sutton system is implementing **"*Community Voice*"** group which is co-chaired by Primary Care Network Clinical Director for Health Inequalities and Population Health and members of the community on a rotational basis. The Group is a sub-group of the Health Inequalities and Population Health Management Programme Board.

The Community Voice will provide the infrastructure that will enable Sutton system to consolidate community engagement activities relating to Sutton Health and Care Plan and broader priorities. It is anticipated that Community Voice would be the mechanism for engagement and co-creation of strategic health and well-being solutions at Sutton Place and neighbourhood level.

Details about the operation of Community Voice initiative will be co-produced with local residents and communities.

Charities, Voluntary Sector Organisations and Community Health Champions
Building on the success so far, charities and voluntary sector organisations alongside Sutton Community Health Champions will continue to play a critical role in engaging local communities and activating grassroots community groups to work with place-based partners to focus on utilising community assets and opportunities to address the wider determinants of health such as access to training and development, employment opportunities and volunteering.

Our community health champion model and 267 charities and voluntary sector organisations have the potential to deliver further and faster to the most disadvantaged communities. We need to consider with stakeholders how we build on extensive engagement and trust that has been built with communities to develop community resilience and long term recovery from the impact of COVID-19.

We are committed to the concept of using a community asset-based approach, where multiple deprivation is evident to secure the right interventions, for the right people, at the right time - leading to sustainable outcomes for individuals, families and the community more broadly. For example, despite the challenges of COVID-19, Sutton Council Public Health, charities and voluntary sector organisations collaborated during the pandemic to distribute emergency food parcels, triage cases for additional help and support from the Community Hub (based at Hill house in Carshalton). The future aspiration is that the Hub will serve as a Community Wellbeing Zone which will be strategically located to support local initiatives targeting areas of deprivation such as Central Sutton, Wallington, Beddington, The Wrythe, St Helier and Wandle Valley.

Neighbourhood wellbeing hubs
Sutton PCNs are committed to establishing four neighbourhood wellbeing hubs that are aligned with the four PCNs. The approach will ensure that residents have personalised, coordinated and simplified access to community-based activities, support and enablement which will benefit their health and wellbeing supported by health coaches, social, welfare and employment organisations.

The neighbourhood wellbeing hubs will bring together teams of voluntary sector, community organisations and primary care.

Social Prescribing

In Sutton, social prescribing has emerged as a highly creative and collaborative approach and potential enabler in our joint response in engaging with whole population, reducing inequalities in access and outcomes for all. The Social Prescribing Service (provided by Age UK Sutton) service employs six Social Prescribing Link Workers and a Head of Service delivering support to residents across the Borough of Sutton. Each primary care network has a dedicated Link Worker, with a further two Link Workers focusing on higher need patients referred through the Sutton Virtual Ward programme. The development and evolution of the service has been a result of focused collaboration between the primary care networks, Sutton Health and Care Community Service, and the wider system. Ongoing engagement with GPs, Practice Managers, and other practice staff has resulted in steadily increasing direct referrals to the service. The service is beginning to open up to direct referrals from members of the public as well.

Building on the success of the existing service for people aged 18 years and over; Sutton Council Public Health is looking to potentially co-fund an expanded model of social prescribing services. Current discussions include widening of social prescribing to meet the diverse needs of the population such as children and learning disability. There is a strong desire across the system to consider how Social Prescribing can be developed and expanded, and the types of services and activities Link workers might refer to, can be supported to be more sustainable

The work of the Sutton Social Prescribing Service (Age UK Sutton) provides us with a local example of how social prescribing can be instrumental in ensuring that individuals are connected to community resources and are given the opportunity to discuss what matters to them

Spotlight on Social Prescribing Sutton

Social Prescribing Sutton is an all-adult service that forms part of the wider Primary Care Network (PCN) teams across Sutton. Working alongside health services, we support individuals in a fully holistic way to understand their motivations, overcome their barriers, and achieve their goals. Our unique position within the Sutton community allows us to connect patients to a range of non-clinical interventions and activities that can help them take greater control of their overall health and wellbeing, and achieve positive, long-lasting changes in the areas that matter most to them. Age UK Sutton is the hosting organisation for this all adults (18+) Social Prescribing programme, working with Sutton GPs, the Sutton GP Federation and Sutton Health and Care programme. The service is managed by Age UK Sutton but is 'white labelled' to the public, with clear independent branding to ensure that adults of all ages can understand that the service is available to them. Sutton Carers Centre is subcontracted to provide supervision to the Link workers, and there is a lead GP who meets with the team monthly and is the key contact in the PCNs.

How is the service delivering for Sutton?

As the borough continues with its recovery from the pandemic, we have seen demand for our service increase. Link Workers provide support where it works for the patient – this could be at home, in the community, or at the GP practice. In recent months we have focussed on integration within the PCN teams and having more of a presence within our community. Link Workers are embedded in GP practices as well as attending community events to reach out into the key communities the service serves. The objective of Link Workers is to link patients to support and services that will help them to achieve their goals, after working in depth with them to understand their story. It is frequent that the presenting issue is the 'tip of the iceberg' and with careful, skilled engagement, the Link Worker can identify the full story. Working in this way reduces the risk of a 'revolving door', as we are more likely to identify the core issues and be able to offer sustainable solutions. Social Prescribing relies on the availability of local services, and sustainable funding for these – as present, more services and groups are reopening after Covid, however the picture is still mixed. The team continues to work to identify service gaps and reports these via contract reporting and the steering group.

Key issues that patients are supported with are (in order of frequency, highest to lowest):

- Mental Health and bereavement
- Access to social groups, befriending, and peer support
- Financial and benefits advice
- Practical advice and support (e.g., housing adaptations)
- Housing
- Care
- Advocacy and Welfare rights
- Carer (unpaid) support

As part of service delivery, Link Workers conduct a person centred assessment to ascertain needs, challenges, and to set goals. This bespoke assessment includes an embedded accredited wellbeing score tool, LEAF-7. The most recent data shows patients receiving support from Social Prescribing reporting:

- **A more than doubling of 'Life satisfaction' score**
- **A 50% increase in feeling completely or mostly in control of their health management**
- **A 50% reduction in the number of patients reporting that they were hardly or never able to do the things that are important to them**
- **A more than 50% reduction in the number of patients reporting that they could not live the way they choose**

Patient Feedback

- **"You have made me relax and if I felt like crying, I could cry and I haven't felt judged by you at any point. You have made me think about things and I now think more positively. I would recommend anyone to work with you and they will feel listened to like I did."**
- **"Thank you for listening and all your help and suggestions - in all the 20 years we have never spoken to someone in-depth about what help is out there. It is really reassuring to know that I can get help in the future if things change."**

Population Health

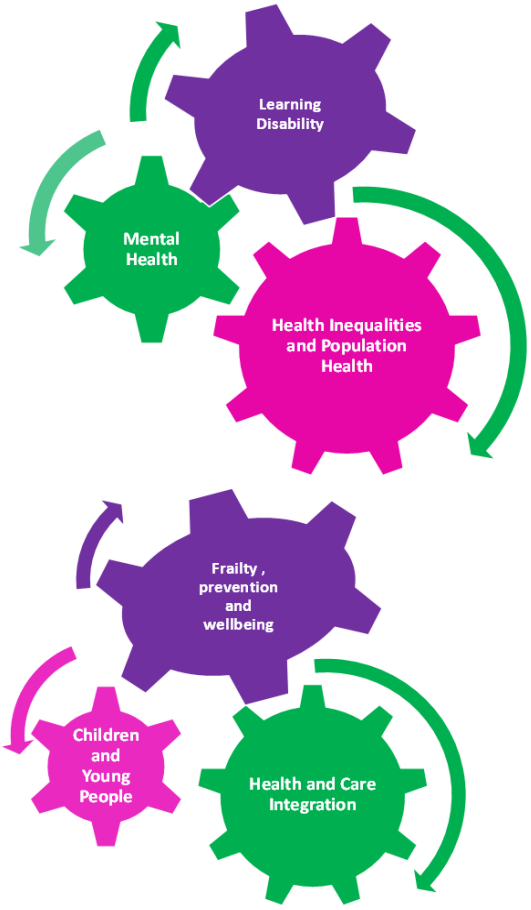
The Lifecourse Approach to Population Health

To achieve our vision to reduce health inequalities, this plan builds on existing work and sets the direction of travel for health and wellbeing across Sutton.

Our starting point in the 2019 plan, which we are building on in the refreshed plan; is the lifecourse approach of **Start Well** (children and young people and their families), **Live Well** (working age adults) and **Age Well** (promoting wellbeing in older people or frailty as a result of age or condition). These are not mutually exclusive as some issues spread across the lifecourse. For example, there is commitment to recognise the needs of young carers, older carers and victims of abuse throughout the lifecourse. The overriding principle is to organise issues and programmes in a way that reduces duplication and repetition.

Our joint response to health and care challenges identified in this plan have been framed around **six interconnecting Sutton Health and Care transformation programmes.**

Start Well	Children and young people including young carers
Live Well	Learning Disability, Mental Health, Health and Care Integration and Health Inequalities and Population Health Management
Age Well	Frailty including prevention and wellbeing



The outline of each lifecourse themed section are as follows:

- Background
- RAG status update on commitment made in 2019
- Programme outcomes
- Key issues and challenges including impact of COVID-19
- 2022/23 programme plan including progress to date and how we know we are making a difference
- Where relevant, quotes, case studies and spotlights (local examples of good practice) have been included.

Start Well

Background

Sutton is a great place for families to settle, raise their children, and enjoy a good quality of life. The majority of local children have supportive families, access to good education and services, and a strong sense of community. These factors help them to thrive and succeed. However, in Sutton, as in most other parts of London, too many children are not able to benefit from the opportunities and support available to them[3]. In Sutton we have a range of services that support children, young people and their families around mental health:

- Schools
- Voluntary and community sector provision
- Child and adolescent mental health service (CAMHS) tier 2 and 3
- Children and young people mental health crisis line
- Accident and emergency
- Mental health inpatient beds (Tier 4)

Update on commitment in the 2019 Plan

Traffic light system – red outstanding, green - completed and amber in progress

1. Implement a trailblazer enhanced mental health support pilot for children and young people in schools	G
2. Continue the perinatal and infant mental health network (PIMH) with new projects on infant mental health, patient and public engagement and fathers and partners	A
3. Undertake a joint health and local authority review of our children's services	G
4. Review and redesign the information and support offer for parents of children with Special Educational Needs and Disability (SEND)	G

The 2022 - 24 outcomes for Start Well are:

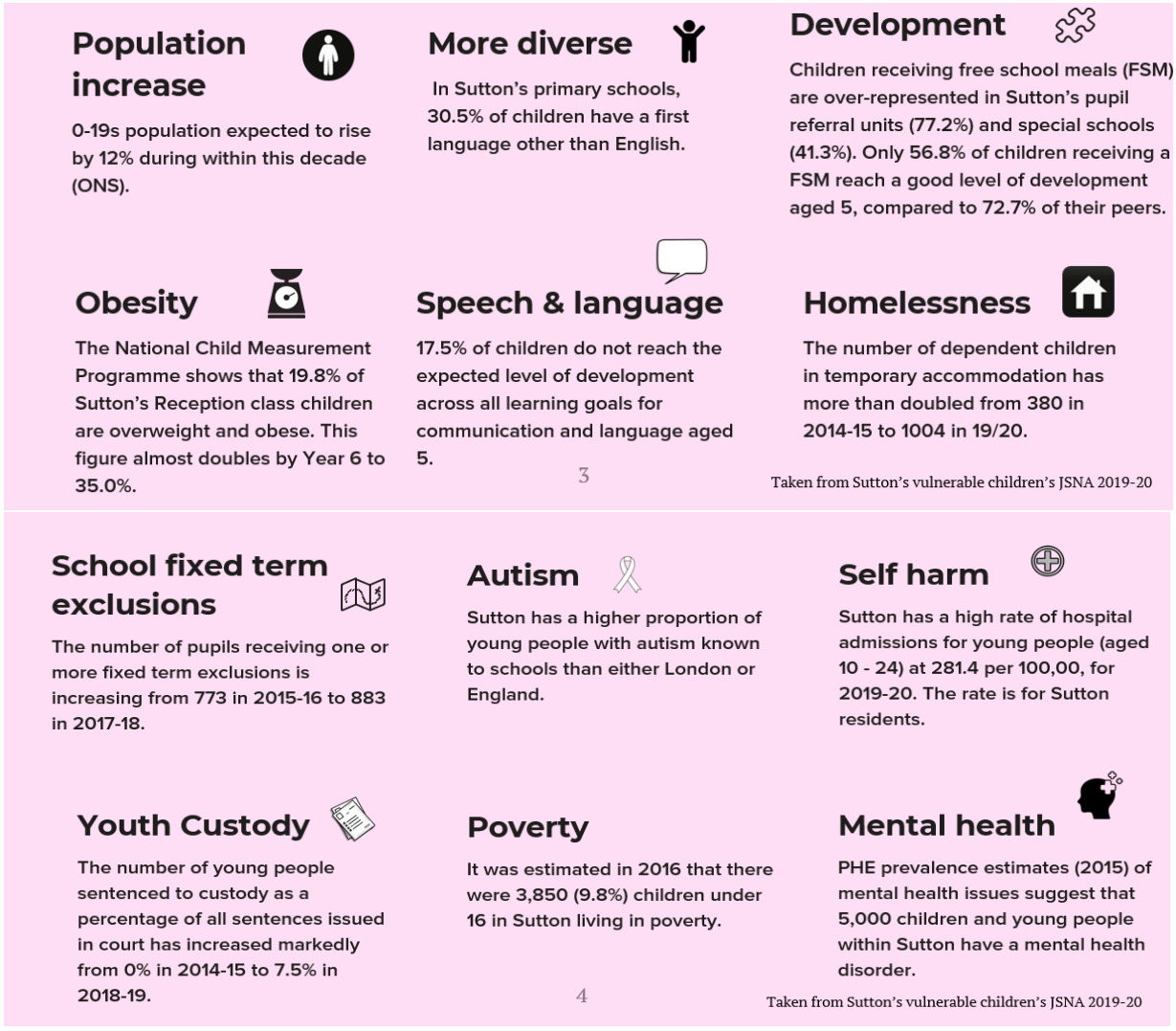
- Reduction in referrals to Children First Contact Service for targeted support
- Decrease in the rate of accident and emergency attendances for self-harm for children and young people
- Relational model is embedded across the system for children, with children and families identifying and working with their trusted adult as the lead worker
- Increased level of school readiness
- Reduction in fixed term exclusions
- Evidence of children and parents shaping work
- Increased number of children and young people participating in the shaping and review of services
- Increased number of services been offered alongside Children Centre Services
- Parents who have undertaken a parenting programme feel more confident as a parent and have better understanding of attachment.
- Increase in the number of children who are 0-5 years old, identified with complex needs and offered support based on need.

[3] Sutton Borough Annual Public Health Report (2019/20) – Helping Every Child to Thrive _8a__Public_Health_Annual_Report__FINAL__.pdf

- Parents and Carers who have children with Special Education Need, report to having experienced a coordinated approach to support in Sutton.
- Residents report to feeling more informed and able to find out what support is available for them.

Population Insight[4]

According to the Children and Young People from the Joint Strategic Needs Assessment (2019), Sutton has a population of approximately 207,900 people, a quarter of whom are aged 19 years or younger. The wards with the largest populations of 0 - 19 year olds are St Helier and Wandle Valley.



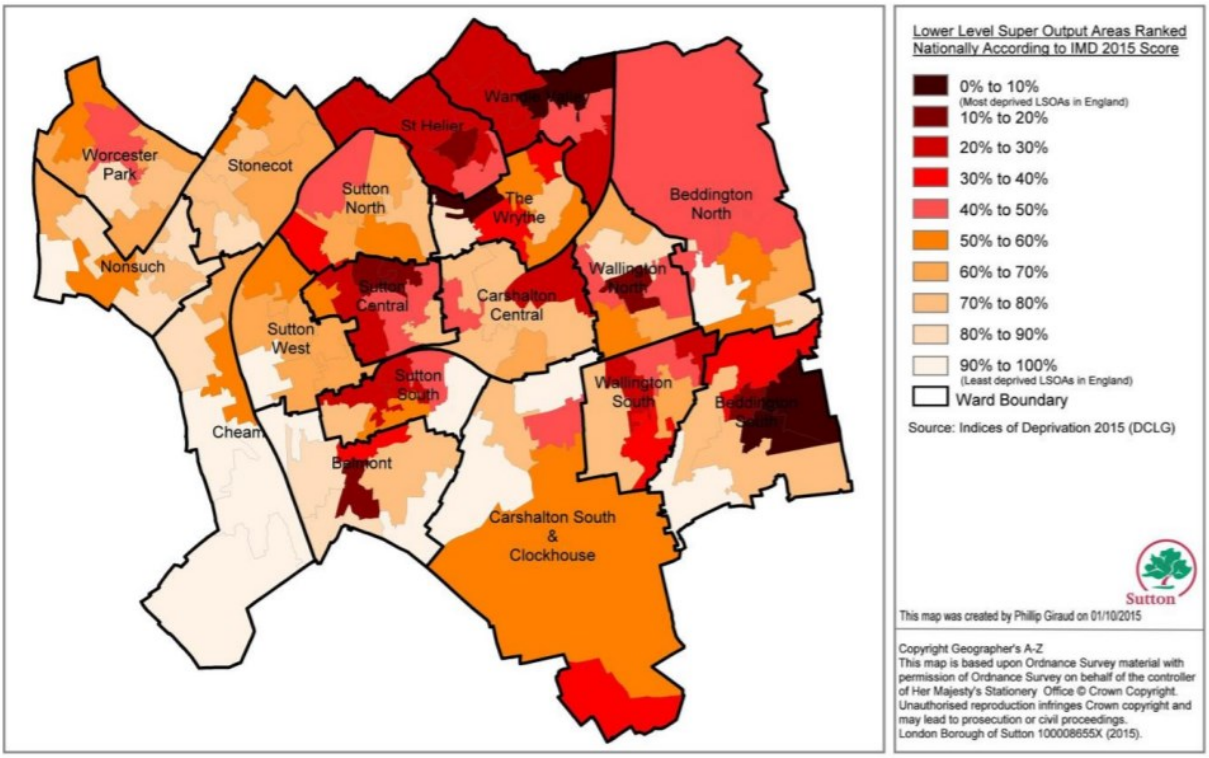
Source: Sutton 's vulnerable children's JSNA (2019-20)

[4]Children and Young People from the JSNA
https://www.suttonlscp.org.uk/static/professionals_files/Childrens_Joint_Strategic_Needs_Assessment_(JSNA).pdf

Income deprivation affecting children

The Index of Multiple Deprivation measures relative deprivation for small areas such as neighbourhoods. It is widely used to highlight the most deprived areas and to focus services and resources where they can have the most impact. The Income deprivation measures the proportion of the population experiencing deprivation relating to low income.

Figure 4: Income deprivation affecting children



Source: Sutton JSNA

The map represents children aged 0 - 15 years living in income deprived households. There are 10 areas in the most deprived quintile. Four of these areas are in the most deprived 10% of lower-level super output areas in England, two in Beddington South ward, one in the Wrythe and one in Wandle Valley.
In Sutton, there are 23 areas in the least deprived quintile. Looking at the borough as a whole, children living in the most deprived wards such as St Helier, Wandle Valley, Beddington South, Sutton Central and Wallington South are more affected.

Obesity

The maps suggest that in St Helier, The Wrythe and Wandle Valley rates of childhood obesity are significantly worse by Year 6. For these three wards the rate is higher than England (34.2%). In Sutton, the proportion of children who are overweight and obese varies considerably by school and age (Reception 12% - 33% and Year 6 between 19%-46%).

Children and Young People's Mental Health

Anxiety remains the main reason for referrals to child and adolescent mental health services with COVID-19 causing increase in symptoms around health anxiety in some instances. Some anxiety for children and young people around social situations and school therefore showed significant improvement during the time schools were off.

Public Health England prevalence estimates (2015) of mental health issues suggest that 5,000 children and young people within Sutton have a mental health disorder.

The number of young people sentenced to custody as a percentage of all sentences issued in court has increased markedly from 0% in 2014-15 to 7.5% in 2018-19.

Key issues and challenges

There are a range of challenges facing children and young people in Sutton

- **School readiness** - We know that not enough of our children are ready for school by the time they reach their reception year. This mean that too many children are not reaching desired levels of emotional, social and physical development combined with low levels of basic numeracy and literacy. We know that this is important as a child who hasn't benefited from the right level of emotional support at homes and in the community is unlikely to thrive at school and may struggle with simple tasks such as sitting at a desk paying attention, socialising with other children or eating or going to the toilet.

- **Children with Special Educational Needs and Disability** - Another inequality that we have to tackle is the need to maximise chances for children with Children with Special Educational Needs and Disability. Since our last OFSTED inspection partners have been working hard to improve the fairness and transparency around assessment of need and the subsequent provision of support. We need to continue this process so that we maximise opportunities for children with lower levels of need to be schooled and supported within mainstream education whenever possible which we know from the evidence leads to better outcomes while at the same time maintaining good levels of specialist provision for those who need it.

- **Children and young people with mental health -** Rapid changes in society from increasing childhood poverty and changes in family structures to the rapid rise of social media or the increasing drug use amongst young people, all contribute to increasing levels of stress and anxiety amongst young people. Demand for children and young people mental health services continues to grow, acuity is more complex particularly post COVID- 19, and some waits are long.

- Children receiving **free school meals are over-represented in Sutton's pupil referral units** (77.2%) and special schools (41.3%). Only 56.8% of children receiving a free school meal reach a good level of development aged 5, compared to 72.7% of their peers.

- As with national data there is **a high proportion of children with disabilities who live in the areas of the borough with higher deprivation**. Statistically most children with disabilities live in the **St Helier ward**, this is also where most children in low income families in the borough live.

- There are also high proportions of children with disabilities in Wandle Valley, The Wrythe and Sutton Central. A review of Special Education Needs was performed by Public Health

in 2014 indicated there was a perceived changing profile of need, especially reports of more children and young people diagnosed with autistic spectrum disorder and more children with severe and complex impairments.

- **Demand has risen for child and adolescent mental health services provision -** Child and adolescent mental health services referrals and children and young people presentations at accident and emergency reduced as the pandemic impacted during 2020/21. There has been an upward trend in referrals particularly as schools returned in September 2020, and overall, referrals have returned to pre-pandemic levels.

- **Increasing acuity and crisis presentations** - mental health crisis is presenting as more intense and harder to manage as often families and young people had held off presenting. This has led to an increase in suicide attempts. Self-harm has increased since schools have returned. Triggers are often school stresses or friendship issues.

- **Increase in complexity as some children with autistic spectrum disorder** have significant struggles with change in routine and loss of stable structure leading to increased anxiety and challenging behavior.

Impact of COVID-19

- Demand for children and young people mental health services continues to grow, acuity is more complex particularly post COVID- 19, and some waits are long
- Feedback from schools evidenced increased anxiety, depression and bereavement amongst parents and staff
- Parental anxiety about school closures and reopening has impacted and been fed back through schools, school nurses, families using the helplines and voluntary sector providers.
- School staff especially felt in the beginning that they were the only agency working face to face and that the pressure of this had a detrimental impact on their wellbeing.
- Health and care staff have been supported to maintain their health and wellbeing via employing organisations – employee counselling support, flexible working, additional team engagement/ connection session, ‘fast track’ referral into Improving Access to Psychological Therapies, access to self-help materials around stress, depression and anxiety
- Attention Deficit Hyperactivity Disorder - struggle to manage education online and found it hard to stick to rules around lockdown, lots of impulsive breaking of rules and an increased risk-taking behaviour
- Children with depression have struggled due to isolation, loss of usual distractions and support.

The Horizon Church Learning Hub on the St Helier Estate is an example of local action that is being taken to address low attainment and emotional wellbeing.

Making a difference

Horizon Church Learning Hub on St Helier Estate

Child X had prior emotional problems and had received help within school from the family support worker under the Emotional Literacy Support Programme. Child X thrives in the environment of small working groups. She enjoys the routine and having the adult interaction to give her confidence in her work. We have been able to build a positive relationship with Child X helping her to express her worries and address them together. She worked with one of our volunteers to produce some amazing artwork. The positive response of her school to her artwork served to boost her confidence. Eventually she put herself forward to be a class representative!

This is a direct quote from her Head Teacher: “We have noticed that through attending the Hub, X has grown in self-confidence, she trusts her own opinions more, he is confident to speak out in a group and express her own views and opinions. X has become confident in her ability to lead other children and to offer advice and solutions to others. Since last year X has become more able to speak to adults in school and taking initiative to problem-solving plan.

The quality of homework the X has brought into school has been amazing. In particular, the group (Horizon Learning Hub) has given children opportunities to participate in art projects that they may not have had the opportunity or resources to complete at home. Good quality homework has contributed to X making good progress across all areas of learning in year four and made her ready for year five. We are very impressed with the quality of this provision”

The work of Home-Start Sutton provides us with a local example of opportunities to use volunteering as a mechanism for mobilising communities to make vital contributions to health and wellbeing of local residents.

Spotlight on Home-Start Sutton

Home-Start Sutton has been supporting Sutton children under 5 and their families for 37 years. Our core service recruits local people with parenting experience to provide home-based weekly volunteer support to families with young children in London Borough of Sutton. Additional services include groups and peer advocacy, holiday activities and events and access to practical support such as foodbank referrals, grants for essential items etc We are part of a federated network of independent, locally governed, managed, and funded Home-Start schemes.

We currently have 88 local volunteers supporting families. We work in partnership with a range of statutory and voluntary sector organisations to support children and families. Our referrals come from health visitors, social care, children's centres, self-referrals and other voluntary organisations. In 2020/21, we **supported 322 families with 400+ children through our home-visiting volunteers, peer advocacy, groups and parenting programme and trained 19 new local volunteers.**

- 84% of parents report feeling less isolated
- 88% report improved confidence and self-esteem
- 70% were supported to increase access to local services and support
- Volunteers gave over 5,000 hours of direct support to families

Additional Services Snapshot

- **Nurturing Parent Programme a parenting course for parents with children under 5**. Helping parents attune to their children's needs, practice positive discipline, manage challenging behaviour, cope with stress and the importance of nurturing themselves and their children.
- **Domestic Abuse Nurturing Parent and Child groups** – as part of Transform partnership, a parenting programme, for women and their children under 5 affected by domestic abuse, including direct support for children, and focussed on 'buffering' the effects of domestic abuse on children through enabling a deeper understanding of young children's emotional and developmental needs.
- **Family Support Groups one in Carshalton for isolated parents and children under 5**, where they can meet other parents in a safe nurturing environment and Tea and Tots in Sutton for parents and under 2's. Aimed at parents with low mood/mild to moderate mental ill health.
- **Sutton Parent2Parent Independent Advocacy Service**. A project to support parents to engage with the child protection process. Parents with a Child Protection Conference are offered peer advocate support before the conference, support within the conference and de-brief. This has been delivered for 6 years and now LBS funded for 1 year.
- **Bridge the Gap** – joint project with MAPS, Volunteer Centre Sutton, offering mentoring to parents of young people 10-18 at risk of exclusion (school or social) or of getting involved in the criminal justice system.
- **The Pod** - Temporary Accommodation Project a weekly welcoming non- judgemental 'drop-in' for parents and under 5's in temporary/insecure accommodation.
- **Bringing Mums Together** – perinatal project, weekly group in Sutton, with Sutton Mental Health Foundation for new mums and babies under 1. Reducing isolation, and a safe space to share experiences and make friendships.
- **Maternal Journal** –perinatal project, creative journaling group for well-being for pregnant and new mums.
- **Moving on Together –** joint project with Playwise, offering post-diagnosis support to families with a child with additional needs/disability. Weekly volunteer support.

A Shared Children and Young Peoples' Programme

The Sutton Children's Delivery Board has been established to provide strategic leadership, direction and focus, promoting innovative, integrated, collaborative or joined up and cost effective solutions (or services) for the priority problems faced by Sutton's children and young people. The Sutton Children's Delivery Board is leading a two-year review with a focus on children 0-5 having the best start in life.

The review has led to four pilots - Universal Parenting, Speech and Language, Start Well brand and Communications and the Child Development Service. The shared children's plan includes priorities for Helping Early and Child and Adolescent Mental Health. The Shared Plan is now ready to be integrated within services. Each service lead joining up priorities, outcomes measures to support implementation and evaluation against the Shared Children's Plan.

Children's services including young carers plan

What progress have we made so far?
• We have developed profile of young people in Sutton, highlighting the complex needs that may arise within their family, their mental and physical health issues and their engagement with statutory services. (0 - 25yrs) • We developed together, a strategy that sets out 8 priorities for us to best respond at the earliest opportunity, providing the right support at the right time for children & families 0 - 25yrs old
What do we plan to do next?
• Our plan to develop family hubs as a system, working with children, young people and families • Implement our empowering parents and communities' model - implementing parenting programmes to support universal parenting, families experiencing conflict at home, and families with children with Autism Spectrum Disorder or Attention Deficit Hyperactivity Disorder. • Implement Roundshaw Project supporting children and families
Planned activities for 2022/23
• Develop family hubs in Sutton to support integrated service offer for families • Develop champion groups for children and parents, to support the shaping of early intervention services • Conduct a community focussed review of our Children's Centres in Sutton to recommend a future delivery model that prioritises relationships • Develop a universal offer to parents with children aged 0-5, overseen by a Parenting Coordinator. • Trial an Independent Domestic Violence Advisor being co-located in Tweeddale Children Centre to be easily accessible for parents once a week, and to provide informal early advice and guidance for professionals • Develop our data capturing to better understand the children and families accessing services; ethnicity, needs, location. • Respond to community need through co-produced project in Roundshaw, responding to inequality and poverty • Transition points are improved for children and young people receiving emotional and mental health support

How do we know we are making a difference?

- Number of referrals made to Family Hubs
- No. of children and parents engaging in shaping the work through participation groups
- Number. of children and families engaging in work per year.
- Number of professional enquiries to Independent Domestic Violence Advisor when present at Tweedale.
- Number of parents who access support from Independent Domestic Violence Advisor at Tweedale
- Number of children, families accessing support from the multi-disciplinary team
- % of children and families that feedback that they are getting earlier help as a result of the multi-disciplinary team
- % children & young people reporting improved mental and emotional health as a result of mental health support intervention at school

What difference will this make to children and young people in Sutton?

- Residents report to feeling more informed and able to find out what support is available for them.
- Increased number of self-referrals into Helping Early Services listed on the one directory.
- Increased participation from children and parent/carers in service development and delivery
- Increased number of services offered within and alongside Children Centre Services
- Parents who have undertaken a parenting programme feel more confident as a parent and have better understanding of attachment.
- Professionals report increased confidence and earlier intervention as a result of informal advice from the Independent Domestic Violence Advisor based at Tweeddale Children's Centre.
- Increase in parent/carers receiving support from Transform as a result of the Independent Domestic Violence Advisor based at Children's Centres.
- Families living in temporary accommodation feedback that they understand how to access support they might need

Children and Young People with Mental Health Plan

What progress have we made so far?
• Mental Health Support Teams in schools developed a YouTube channel which contained a host of different video content to support parents, children and professionals. • Work around auditing domestic violence support was carried out at Carshalton Boys' Sports College • Promotion of digital resources such as Kooth online counselling. Kooth is known to support young people who may not traditionally engage with traditional face-to-face therapy. • Roll out of the Mental Health Crisis Line which offers emotional support and advice to people who are affected by urgent mental health issues, at any time of the day or night. It is open to everyone: both children and adults of all ages, and to people who haven't previously accessed mental health services • Development of emotional wellbeing: COVID-19 resource hub for help and support during the pandemic. The hub includes our preferred links and advice for children, young people and anyone supporting a child or young person in South West London.
What do we plan to do next?
• Participate in system led work to develop vision and strategic approach to children and young people's mental health transformation, redesign and planning; need to set standards and expectations to 'level up' at system level. • Need to map and understand current commissioning provision for children and young people mental health services and identify gaps. • Our 5 school clusters are developing school action plans to improve the environment of school to better meet the needs of children and young people with mental health issues. • Develop 0-2 CAMHS pilot that will link closely children's centres, early help, paediatrics and early years services. • Increase capacity of short term therapy and counselling pathways to ensure we can meet demand
Planned activities for 2022/23
• Resource has been agreed for Sutton and Wandsworth to pilot the learning disability and Autistic Spectrum and Disorder key worker initiative. This will commence in 2022. • Development of a seamless CAMHS offer for 0-25 year olds • Create a positive behavioural support post so the local area is less reliant on expensive spot purchase arrangements.
How do we know we are making a difference?
• Number of children and young people accessing early help information, support and services • Number reporting increased access to support in the community • % of children and young people, families and carers and referrers that provide positive feedback on the information available • % of children and young people from BAME backgrounds accessing child and adolescent mental health services • % children and young people reporting improved mental and emotional health as a result of mental health support intervention at school
What difference will this make to children and young people in Sutton?
• Improvement in children and young people's mental health and resilience • Children and young people report improved mental and emotional health as a result of mental health support intervention at school • Children and young people feel involved in created decisions affecting their mental health

Children with Special Educational Needs and Disability Plan

What progress have we made so far?
• London Borough of Sutton has partnered with a local college to provide the placements from amongst its own services. Students starting in September 2021 with support for the placement coming from Orchard Hill College tutor and job coach, together with mentors in each of the teams offering a placement. • We utilised the Wellbeing for Education Grant provided to the Sutton Council to commission South West London and St George's Mental Health Trust and Cognus to provide training on emotional well-being recovery to all schools in the borough. • Cognus has re-introduced the call back services for parents and schools who wish to speak with an educational psychologist, implemented virtual consultations for primary schools Special Educational Needs Coordinator and teachers, produced guides for parents for children with a broad range of needs and proactively contacted 1,800 Sutton families with an Education, Health and Care Plan.
What do we plan to do next?
• Develop clear transition pathway and processes that are understood by families, carers and individuals going through transition pathway • Design Pathways into Employment (paid or supported) internships or apprenticeships • Develop Special Educational Needs and Disability joint commissioning strategy • Continue work with schools to ensure children, young people and schools have more effective support so that they can stay in mainstream education and learning
Planned activities for 2022/23
We will define planned activities for 2022 -23 as a minimum we will establish a co-production protocol with Sutton Parent Carer Forum, which will include a schedule of engagement and mechanisms for escalation, reporting issues and tracking progress, to ensure that families are at the heart of change
How do we know we are making a difference?
• Decrease in number of complaints relating to the Education, Health and Care Needs Assessment process • Increase in access to mediation - take up of mediation as opposed to only getting a certificate • Reduction in the number of Special Educational Needs Appeals • Decrease in the numbers of children with Special Educational Needs Support who have either first or permanent exclusions
What difference will this make to children and young people in Sutton?
• Families and young people are able to access a wide range of services in the borough • Young People's wishes, attainment and aspirations are understood, and measures are in place to track and manage their journey • Young People with Special Educational Needs and Disability have a range of opportunities for employment/ apprenticeships/ traineeships. • Young people's aspirations permeate the Education, Health and Care Plan and inform decision making within the legal framework. • Strengthened relationship between families and the local area.

Live Well

Background

The NHS Long Term Plan describes personalised care as one of the five major, practical changes needed to achieve the new NHS service model of the 21st century, over the next five years. Personalised care requires a fundamental shift in focus from traditional medical models to approaches that enable people to exercise control over decisions about their health and that of their communities. Leading to a whole system approach to joined up assessments, personalised care and support planning and integrated budgets

Live Well strategic theme will support vulnerable people such as people with a learning disability and mental health issues and encouraging adults to make healthy lifestyle choices. The key here is a real focus on reducing health inequalities through better understanding of the health and care needs of the population.

The programmes supporting Live Well theme include the following:

- adult mental health programme
- learning disability programme
- health and social care integration programme
- health inequalities and population health management programme

The programme of work will include addressing key wider determinants of health such as work, focusing on whole system approaches to the key lifestyle risk factors of smoking, physical inactivity, obesity and alcohol that are driving premature mortality, inequality and illness, and developing new service responses that support general practices to work differently with people who face severe disadvantage.

Update on commitment in the 2019 Plan

Traffic light system – red outstanding, green - completed and amber in progress

1. Improve the specialist support provided for adults with learning disabilities	G
2. Undertake a joint health and local authority review of how we commission services for people with learning disabilities in Sutton	A
3. Review and redesign the information and support offer for people with learning disabilities	G
4. Use population health intelligence to more effectively identify and target interventions and services for people living with a long term condition	G
5. Improve the link between primary care and community assets to further support self - care	A
6. Implement the Integrated Improving Access to Psychological Therapy long term condition service model	A
7. Implement a planned care transformation programme	A

The 2022 - 24 outcomes for Live Well are:

- People with Serious Mental Illness will have better access to, experience and outcomes of community based mental health care within Sutton
- People with a learning disability and serious mental illness will be supported to assess their physical health needs and access appropriate support to improve their physical as well as mental health and wellbeing

- People are supported to live as independently as possible at home and to return home quickly and safely, after a hospital admission
- Resident's report feeling more in control of their health and well-being.
- Increased self-care by people with Type 2 Diabetes evidenced by reduction in GP attendances

Domestic Abuse

There are some 2.3 million victims of domestic abuse a year aged 16 to 74 (two-thirds of whom are women) and more than one in ten of all offences recorded by the police are domestic abuse related. According to the Office for National Statistics (ONS) report in mid-May 2020 regarding the impact of lockdown on domestic abuse a 12% increase in the number of domestic abuse cases referred to services. Between April and June 2020, there was a 65% increase in calls to the National Domestic Abuse Helpline, when compared to the first three months of that year[5].

The government's Domestic Abuse Act 2021 seeks to create a statutory definition of domestic abuse, emphasising that domestic abuse is not just physical violence, but can also be emotional, controlling or coercive, and economic abuse. It places a duty on Tier 1 local authorities in England and Wales to provide accommodation based support to victims of domestic abuse and their children in refuges and other safe accommodation

Sutton's Approach
Sutton has developed a multi-agency approach to supporting victims of domestic abuse and addressing behavioural change in perpetrators of domestic abuse. Our local response to domestic abuse is overseen by the Safer Sutton Partnership Board as the statutory board with responsibility for domestic abuse in Sutton. The SSPB is supported by the Domestic Strategic Partnership Board which has membership representation from London Borough of Sutton, SWL CCG, Sutton Housing Partnership, Encompass, Mental health Trust, Sutton Health and Care, Community Action Sutton, primary and secondary schools' rep, Epsom and St Helier NHS University Hospitals Trust supported by the Domestic Abuse Multi Agency Risk Assessment Conference (MARAC) and the Drive Core Group which promotes as much local ownership as possible by ensuring that key decisions affecting local service provision is made in consultation with local stakeholders

Support for domestic abuse victims and children, and a behavioural change programme for perpetrators is delivered through an integrated, specialist service that is commissioned through a Lead Provider model led by Cranstoun and known as 'Transform'. Cranstoun manage the Independent Domestic Violence Advisors One Stop Shop and deliver Men and Masculinities programme. Other organisations sub contracted by Cranstoun and partnering to provide our local provision are Limes College delivering prevention and early intervention to young people; Hestia manging a ten refuge in the Borough; and Sutton Women's Centre delivering the Freedom programme as well as Jigsaw4u delivering peer befriending and Homestart working with young families.

Population Insight

- Domestic violence is an issue in Sutton, accounting for more than a third (38%) of all incidents of violence with injury in the borough in 2017. However, as domestic abuse is

[5] Domestic abuse in England and Wales overview - Office for National Statistics (ons.gov.uk)

a crime that often goes unreported, the actual number of cases is likely to be higher. Low income, economic strain, and benefit receipt are all risk factors for domestic abuse[6]

- The 'Transform' programme has worked with 2,583 victims and children, and 166 perpetrators of domestic abuse since the contract went live in November 2019
- 100% victim respondents reported feeling safer upon case closure and 97% reported that abuse had reduced or stopped
- The refuge has had an average occupancy rate of 95%
- Independent Domestic Violence Advisor referrals have increased every quarter since the start of the contract
- Maternity data shows that in 2021, 88 women disclosed domestic abuse to hospital staff
- At least 61% of child protection cases in our borough include domestic abuse as a factor
- There is a link between mental health, high suicide rate and domestic abuse. One in seven (14.2%) children and young people under the age of 18 will have lived with domestic abuse at some point in their childhood. Children can experience both short and long term cognitive, behavioural and emotional effects as a result of witnessing domestic abuse. Each child will respond differently to trauma, and some may be resilient and not exhibit any negative effects. Some of the effects can include; anxiety, depression, sleeping difficulties, physical symptoms, anger problems, regression, aggression, low self-esteem, eating disorders, self-harm, substance misuse, exhibit violent behaviours and fear

Progress to date

- We have been successful in attracting additional funding (outside of the core budget and commissioned service) as follows. However, this is all time limited and not guaranteed beyond the terms stated.
- Implementation of Drive Project to tackle high risk, high harm perpetrators including additional Independent Domestic Violence Advisor. Agencies work together and mental health are a key component of this project (MOPAC)
- Early intervention and accommodation project in children's social care and housing to work with low level perpetrators at an earlier stage, including training for 80 Sutton's Close Supervision Centre.
- Three additional posts at the refuge: Play worker, Transitional worker and Psychotherapist
- St Helier Hospital has an Independent Domestic Violence Advisor co-located there to work with referrals directly from A & E, material services and any other dept.

Opportunities

- Raise awareness and understanding about the devasting impact of domestic abuse on victims and their families through ongoing specialist domestic abuse training for all frontline practitioners and decision makers
- Additional investment is needed in behavioural change programme for perpetrators without compromising support for domestic abuse victims if the root cause of domestic abuse is to be tackled meaningfully over a long period of time

[6] Sutton Plan Partnership (2019) Domestic Abuse in Sutton – Research Report. Available at: https://notaloneinsutton.org.uk/wp-content/ uploads/2018/07/Sutton-domestic-abuseresearch-report.pdf

- There is an opportunity for Sutton Place to employ a dedicated domestic abuse specialist worker, who can act as a single point of contact for primary care, support GPs predominantly by helping with referrals into services and the MARAC, as well as training and advice on cases, including the need for routine enquiry. This role would be a huge move forward in joining up the domestic abuse response for our borough and enabling GPs to continue to do their primary work, whilst ensuring that no opportunities are missed to support people affected by domestic abuse.

Supporting Carers

We know and recognise that unpaid carers are critical to the provision of care and support to adults in Sutton. We know that while the majority of Carers are likely to be female there are a significant number of male Carers. Children and Young People can also be Carers and more needs to be done to identify them. We know that Lesbian, Gay and Transgender
Carers also face particular challenges and are not always identified and recognised

Whilst the support they provide is vital and can be rewarding and satisfying for the Carer, caring can also have negative impacts on carers health and wellbeing and their capacity to lead a balanced life. It is important that these health and well-being issues are addressed because where Carers are not sufficiently supported and are subsequently unable to maintain their caring role, the risk of residential, nursing and hospital admissions for the cared for individual is increased

Nationally it is known that two of the ways to achieve improved outcomes for Carers is to:

- Improve the early identification of Carers and provision of clear, consistent and accessible information and advice about support available and;
- Support Carers to maintain and improve their health and well-being and social inclusion

Locally, the joint Sutton Council and NHS South West London Clinical Commissioning Group (Sutton) sets out the vision for Carers in Sutton **– '**Carers are recognised and valued as expert partners in care and treated with dignity, supported to identify their own solutions, remain healthy, live a good life and continue to care'. **The full strategy can be accessed here:** Draft Sutton Joint Carers Strategy 2019-23.pdf

Population Insight[7]

- There is estimated to be around 18,298 carers in Sutton (estimated 3,000 young carers with 432 formally registered). Of these 3,620 provide over 50 hours care per week. People providing higher hours of care are at greater risk of poor health and social exclusion are therefore likely to need support or information and advice to maintain their own health and wellbeing are not known to health, social care or voluntary sector services.
- Sutton's Carers are predominantly white (84%), and a higher proportion are women (58%) than men (42%)
- There is an over-representation of Carers in Sutton, compared to regional or national averages, caring for people with: learning disability or difficulty (25.2%); mental health

[7] CARERS-Fact-Sheet5.pdf (sutton.gov.uk)

problem and dementia. (Alzheimer's Research UK estimates that there are around 2296 people living with dementia in Sutton)
- Carers are found across the borough but are heavily concentrated in some of **Sutton's most deprived wards (e.g., St Helier, Wandle Valley and Wallington South).**
- Sutton's carers are subsequently at high risk of income poverty, particularly when considering that Sutton has a low proportion of carers (11%) in employment, compared to other London boroughs (24th lowest out of 32)

Progress to date

- Carer Support Services has been formally included in the Making Informed Choice to enable residents maintain the choices that they have made, including their wellbeing. This could be through training, peer support, group work, activities, therapeutic support and one to one support, such as mentoring/emotional support to help to build confidence

Opportunities

We have identified further opportunities in addition to those described in the joint Sutton Council and SWL CCG (NHS Sutton) Carers Strategy Delivery Plan which can be accessed here: Carers Strategy 2019 - Delivery Plan.pdf (sutton.gov.uk)

We recognise that Carers are important to the NHS in supporting:
- Reduction of admissions to hospital and residential care
- Reducing cost of delay transfer of care
- Reduce access to primary care as a result of caring role and reduction of overall spend on care

We will:

- Continue to coordinate access to vaccinations, NHS Health Checks, mental health and wellbeing support.
- Increase the identification of Carers through the roll-out of Carer Passports.
- Appoint a Sutton Carers Support Partnership Lead that will coordinate system support for carers to prevent unnecessary hospital admission by ensuring better interconnectedness between all parts of the local health and care system
- As part of delivery of the Sutton 2 hour community urgent care response, unpaid carers will be trained to recognise signs of deteriorations and act accordingly

Case study example of Carers Support provided by the Alzheimer's Society (Sutton)

Making a difference

Alzheimer's Society (Sutton) Carers Support

Background

I initially spoke with this carer in August 2021. The referral was received from Cheam Resource Centre (Memory clinic) in Sutton. This carer supports her husband who has a diagnosis of dementia. The carer lives with her husband and two adult son and daughter.
The initial telephone assessment with the carer was focused on the support services available both at the Alzheimer's Sutton and in the wider community. We also discussed and how dementia can progress as the carer mentioned that her husband is becoming more forgetful. We also discussed coping strategies for the carer as she had been finding the caring role stressful. We discussed the important of the caring looking after herself.
The carer had been struggling to get in the contact with the people she needed to, for example she had been struggling to get in contact with social services.
The carer's husband attends a day centre 3 times a week, which give the carer some respite, however she feels she needs more time to herself.

Intervention

During assessment we considered various aspects of their lives which could affect their journey with dementia. In the meantime, carer contacted Social Services after her husband had episodes of confusion and became aggressive verbally and physically too. Carer and her husband were referred for carers assessment and needs assessment respectively.
The carer had been offered emergency assessments., however she had not heard back. The carer previously had a named social worker, but she was unsure who to get in contact with. The carer gave permission for me to speak with Sutton social services on their behalf. I contacted Initial contact centre to follow-up on their referrals and ensure there are no unnecessary delays. I also made referral to Admiral Nurses team for further intervention.
The carer was also provided with information of carers Information and Support program run by Alzheimer's Society, and she may join it in future.

Outcome

- Social Services have now contacted the carer and reassured that they will be arranging assessments in coming days.
- She has also spoken with a staff member from the Admiral Nurses Team in Sutton, who has given support over the telephone. The team mentioned that the carer can call at any time.
- The carer is feeling less carer stress. She mentioned that she is planning on going away for a few days, to get some respite from her caring role.
- I agreed with the carer that I will continue to follow up with her have booked in a follow-up telephone call in a few weeks.

Our intervention will also work to achieve following outcomes:

- Enhancing quality of life for people with long term conditions
- Enhancing quality of life for older people with care and support needs
- Reducing social isolation and supporting independence

The carer gave the following feedback:

“I recently got contacted by Rebecca Eaglestone after a referral being made as I needed assistance concerning my husband who suffers from a genetic defect in the brain and subsequently has suffered a couple of strokes as a result of which is showing signs of confusion and dementia.

Rebecca immediately got in touch with me and offered assistance and liaised with social workers and respective team to get me the help I urgently needed.

Rebecca is so friendly, kind and empathetic and a very good listener. I felt very comfortable opening up to her and sharing all I'm currently experiencing with my husband, and she lent me not only a patient hearing but acted upon it and got the right team to contact me and followed up with me.

I'm so touched, and grateful to her. After having come across a few unapproachable & nasty staff, Rebecca is a breath of fresh air! We need more people like her to deal with crisis that I'm currently undergoing.

I wish Rebecca all the very best and a big Thank you, for all her services to me so far.”

Adult Mental Health Programme

Background

In Sutton we have solid joint working relationships between a range of partners for adult mental health service provision and transformation. south west London wide and Sutton specific planning are taking account of the issues and priorities that have been outlined in this plan. In Sutton we have a range of services that support adults and older adults around mental health:

- Primary care
- Increasing Access to Psychological Therapies, wellbeing, social prescribing and primary care mental health support
- Early Intervention Team
- Assessment Team and Recovery Support Teams
- Home Treatment Team
- Older adult community mental health team and memory assessment team
- Mental health crisis line
- Accident and Emergency liaison psychiatry
- Mental health inpatient beds

Feedback from stakeholders, residents and insight from population data have built a picture of mental health needs that has been exacerbated by the COVID-19 pandemic. There is commitment across south west London and Sutton to ensure that residents have access to early intervention, primary care, crisis services and specialist mental health services

> **"***There has been a change in the demography of clients and access from a geographical spread across Sutton. Clients presenting with mental health issues are much younger. They turn up with specific needs and keen to participate in activities***"**
>
> **Lisa Lancefield, Acting Chief Officer, Sutton Mental Health Foundation**

We want to achieve good mental health and emotional wellbeing for all, enabling all who live and work in Sutton to thrive and flourish, and be resilient when facing life's challenges. We will do this by preventing mental health problems and promoting good mental health.

We will take action to reduce stigma and normalise the promotion of good mental health, focusing on community assets and strengths, and the reduction of inequalities in mental wellbeing. Recognising the importance of the wider determinants of mental health we will build alliances and support local actions on the wider determinants and structural barriers to mental health. This gives a wide scope for action to support mental wellbeing. We will engage Sutton communities and seek opportunities to embed mental wellbeing within the emerging model for neighbourhood teams.

Population insight

Depression and suicide rates are experiencing upward trends for both males and females aged 10 years and over. St Helier, Wandle Valley and Beddington South have higher rates of hospital stays for self-harm.

Sutton has amongst the highest years of lives lost and rates of depression, compared to other local authorities in London. This also correlates with higher than average levels of anxiety, and happiness scores.

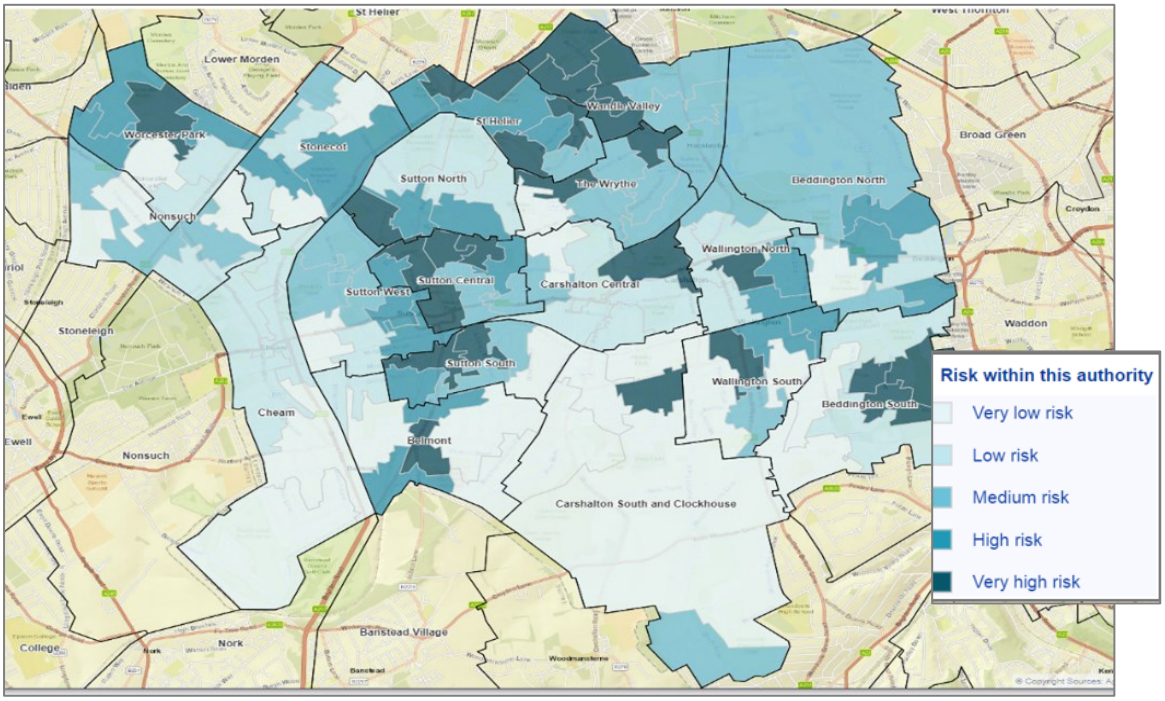
"Depression and lethargy are beginning to set in. Everything has been an upwards battle and because of lockdown I cannot get the outside help that I usually hire in."

Source: **Healthwatch Sutton, COVID-19 Survey**

Health inequalities and risk of loneliness

Sutton residents are ranked 26th least at risk of loneliness of all London boroughs, however when compared to England, **Sutton is within the 50% of local authority areas where residents are most at risk.** Areas at particular risk of loneliness in Sutton generally correlate with areas of higher deprivation, but there are outliers, with neighbourhoods in Worcester Park, Carshalton South and Clockhouse, Wallington North and Wallington South also showing as at very high risk of loneliness.

Figure 5: Health inequalities and risk of loneliness



Source: Age UK

Key issues and challenges

Demand for NHS funded adult mental health services has risen across south west London:

- Referrals to the Adult Assessment Team increased by 21% in 2020/21 and a further 18% in 2021/22 (33% in total)

- Improving Access to Psychological Therapies referrals reduced by 7% in 2020/21 but increased by 21% in 2021/22 and are now exceeding pre-pandemic levels. Improving Access to Psychological Therapies and long term conditions support has increased. Access rate is not yet being met and promotion continues.

- Both the Early Intervention Team and Primary Care Recovery Team referrals reduced and remain below pre-pandemic levels. Home Treatment Team referrals dropped during the pandemic but have now returned to pre-pandemic levels. Sustained pressure on Attention deficit hyperactivity disorder services in terms of assessment and support.

- Older People's Community Mental Health Teams had a 15% increase in referrals in 2020/21 but have now returned to pre-pandemic levels.

- Sustained pressure on working age adult acute inpatient beds and pressure of older adult inpatient wards referrals.

Waiting times

- Patients waiting less than 18 weeks dipped slightly during the pandemic to 96% but has returned to pre-pandemic 98%

Transformation of community mental health services for people with serious mental illness

Sutton is a south west London pilot site for transformation of community services for people with serious mental health illness. A local multi agency group led by the Mental Health Trust was established in March 2021 to oversee the design of the new services. Future community services will be co-produced with service users and carers and be recovery focused. They will:

- Provide evidence-based clinical interventions which are readily available and accessible at the time and location most appropriate to service user needs.
- Be tailored to individual needs and consider population requirements.
- Align with primary care networks facilitating the development of relationships with GPs and other system partners.
- Provide care which can be easily stepped up and stepped down, in a flexible manner without the need for referrals and repeated assessments. This will reduce the number of times that service users 'tell their story'.
- Establish effective links with voluntary and community sector support enabling people to become more embedded within their local area.
- Employ digital and other delivery modes

Adult Mental Health Programme Plan

What progress have we made so far?

At a south west London level:

- The South London Mental Ill-Health Prevention Programme was initiated in summer 2020 between the three mental health trusts, local authorities, Clinical Commissioning Groups (CCG) and community leaders to respond to the psychological impact from Covid-19. Since then, a listening exercise has been facilitated by Citizens UK and nearly 6,000 testimonies were held. Co-production workshops took place in April and May 2021 and at a summit in June 2021, council, community and NHS leaders came together commit their support to a series of 'community asks' articulated as pledges around parental mental health, children and young people, work and wages, access to services and digital exclusion.

- System wide investment has been identified and implemented across mental health services covering crisis provision, inpatient services, community teams, Primary Care Mental Health workers, Improving Access to Psychological Therapies and Autism Spectrum Disorder or Attention Deficit Hyperactivity Disorder to the value of circ. £8m.

In Sutton:

- We are working towards the 60% target for physical health checks for people with Serious Mental Illness Key initiatives to support this include the Meds Call Service Caseload and Serious Mental Health Illness physical health checks for our homeless patients (Sutton is a pilot supported by the SWL Mental Health Transformation Team)

- Sutton PCNs and South West London and St George's Mental Health NHS Trust are jointly recruiting four additional roles as Primary Care Mental Health workers as part of investment across the wider system outlined above. These post-holders will support practices to provide mental health support without onward referral and offer interventions and wellbeing support. Two roles are now recruited; two remain to be filled.

- Sutton Men in Sheds is a positive idea, space, project, programme, opportunity and support group for men from all backgrounds. We aim to offer the chance to engage in meaningful conversations, help prevent self-harm and suicide, offer support around mental health and social isolation or financial crisis.

- There has been Sutton specific mental health investment in the Sutton crisis café, support for homelessness, Autism Spectrum Disorder or Attention Deficit Hyperactivity Disorder assessment and medication support

What do we plan to do next?

We will continue planning for and delivery of the NHS Long Term Plan ambitions for adults with serious mental illness (SMI) in a phased approach. These are outlined below:

- New models of integrated primary and community care for people with SMI will be put in place, including dedicated provision for groups with specific needs
- Access to Individual Placement Support (employment) services will be increased
- Access to Early Intervention for Psychosis services will be maintained and services delivered in line with standards
- People with SMI will be supported to have physical health checks

Other key Long Term Plan ambitions impacting adults also cover:

- Expansion and increased access to Increasing Access to Psychological Therapies long term conditions support offer
- Continued investment in crisis care to ensure 100% coverage of 24/7 age-appropriate crisis care
- Ambition to eliminate out of area placements and continued investment in therapeutic provision within inpatient care

Planned activities for 2022/23

- A key focus will be the ongoing implementation of the community transformation pilot of the new model of integrated primary and community care in Sutton. This will be overseen by the established Design and Delivery Group, with integrated delivery hubs becoming operational.
- The new model will see care tailored to individual needs including employment support for example
- Supporting this transformation work will be the continued recruitment of Primary Care Mental Health workers and the reintroduction of peer support worker services within Sutton GP practices, co-located at Manor Practice.
- There will be a sustained focus on physical health checks for those with Serious Mental Illness, continuing the work started with the Meds Call Service and homeless patients with Serious Mental Illness
- Work will continue with Sutton Uplift on the development of support for those with Long Term conditions

How do we know we are making a difference?

We will define measures that will allow us to monitor if we are making a difference. These will include as a minimum for example:

- The number of people receiving care from new models of integrated primary and community care for adults and older adults with severe mental illnesses
- The number of people on the SMI register with a valid physical health check

What difference will this make to people in Sutton?

- People with Serious Mental Illness will be supported to assess their physical health needs and access appropriate support to improve their physical as well as mental health and wellbeing

Learning Disability Programme

Background

The London Borough of Sutton and NHS Sutton part of NHS South West London Clinical Commissioning Group (CCG) have developed five year Learning Disability Strategy, with the aim of setting out how young people and adults with learning disabilities and their families, can be supported to improve their quality of life and outcomes. The workstreams of the Programmes are – developing a whole system approach, health and health services; living in a place called home and receiving the right support.

The aim of the Learning Disability programme is to ensure that we offer the best possible services and support to people with a learning disability whilst encouraging independence and offering choice and control. We know by doing this it will give individuals the best possible outcomes and ensure improved health and wellbeing.

Population Insight

There is over >1000 people on Sutton GP Practices learning disability register and the joint highest prevalence of people with a learning disability in London (joint with Enfield) ~0.6% (PHE 2019/2020). It is estimated that 0.44% of people in England have a learning disability. In Sutton, the rate is slightly higher, with 0.5% of residents having a learning disability. It is forecasted that Sutton will see an additional 46 people each year for the next 10 years, so around an extra 460 over 10 years. Of these around 90 will have a moderate to severe learning disability and will receive services. This is around a 17% increase on current numbers and again above the national average which is around 10% up until the year 2030. These projections show there is a need locally to increase service provision and ensure we plan well in advance, so we are ready.

Sutton has 43 learning disability residential care homes, one of the highest number in London. In addition, Sutton also has the second highest number of people with learning disability in care homes placements from other London local authorities.

National data – Public Health England Learning Disability Profiles[8]:

- According to the Quality and outcome framework (QoF), prevalence of learning disability is increasing
- People aged between 18 - 34 have the highest representation on the GP learning disability register
- People aged between 18 - 34 have the lowest record of a health check
- There is a high prevalence of diagnosis of severe mental health illness for patients with recorded learning disability for all ages when compared with patients on GP register with no recorded learning disability

[8] Public Health England https://fingertips.phe.org.uk/profile/learning-disabilities/data#page/3/gid/1938132702/pat/6/par/E12000007/ati/302/are/E09000029/iid/200/age/1/sex/4/cid/4/page-options/ovw-do-0_car-do-0

Health and Care of People with Learning Disabilities, Experimental Statistics: 2017 to 2018. Condition Prevalence and Access to Health Services[9]:

- Breast screening – 55.3% of people received breast screening in 2018/19
- There is good uptake of cervical screening by people with a recorded learning disability
- People with a learning disability aged 65–74 are the highest recipient of flu immunisation
- 90.2% of patients with a recorded learning disability received colorectal cancer screening

Key issues and challenges

- We know that people with a learning disability may be more likely to have a mental health condition. Due to COVID we are also now finding that we have an increasing number of young people and adults with a learning disability that also now require mental health services. This is because for many they have seen a significant change to their routine over the last year such as not going into school or college and disruption to weekly activities. Some people have also felt more isolated and haven't been able to see friends and family as often as they would usually have. Often these contacts with people give a person informal support and give positive benefits to their mental health. Additionally, many parents and carers have also found the change in routine difficult and additional caring responsibilities may mean that they are unable to attend work or their daily activities as they would usually.

- We are seeing a continued increase in demand for services and support. There are more people needing services as with better healthcare, more children are surviving with severe and complex needs and moving through transition into adulthood. Also, in general people with a learning disability are living for longer into older age and may have additional health needs as they age.

- Funding is not always aligned with the additional services, support and resources needed to effectively support individuals. We continuously strive to ensure we are both achieving value for money with services but importantly also delivering quality outcomes to individuals.

- The numbers of people with a learning disability locally are increasing, with an associated rise in demand for suitable accommodation and services. We need to ensure that this is considered when planning for the future. In addition, people with a learning disability aren't always living in the least restrictive setting possible. We have too many people placed in residential care homes, often miles away from their family and friends, who could live locally in alternative accommodation, if it was available.

- People with learning disabilities have told us that they want to live independently with support when they need it, including evenings and weekends. Also, they have told us that they want to live near shops, where they can access public transport and other community facilities, and where they can easily visit their families and friends.

- We need to ensure that people with learning disabilities have the opportunity to have purpose and meaning to their day. They will be active members of their community,

[9] NHS Digital Health and Care of People with Learning Disabilities
https://app.powerbi.com/view?r=eyJrIjoiNTYyNDM4MGYtZDRmYi00NTAxLTkzY2QtMjcwZTY2YTQ0MzNkIiwidCI6IjUwZjYwNzFmLWJiZmUtNDAxYS04ODAzLTY3Mzc0OGU2MjllMiIsImMiOjh9

doing ordinary things that are uniquely right for them, and with support that meets their individual requirements.

Specific impact of COVID-19

In Sutton in line with national trends there are higher numbers of people with learning disabilities experiencing diabetes, obesity, mental health issues, higher rates of cancer, coronary heart disease, respiratory disease.

Public Health England (2020) COVID-19 [10]reported:

- The proportions of COVID-19 deaths in people with learning disabilities that were of a person from an Asian or Asian British group, or a Black or Black British group were around 3 times the proportions of deaths from all causes seen from these groups in corresponding periods of previous years, and greater than the proportions of deaths from other causes in 2020. We are ensuring that ethnic data is being recorded as part of the Learning Disability NHS Health Checks

- COVID-19 increased the number of deaths for people with learning disabilities by a greater margin than for the general population across the adult age spectrum. The 10-year age band with the largest number of deaths was 55 to 64 years for people with learning disabilities but over 75 for the general population.

- The crude rate of COVID-19 deaths for adults with learning disabilities in residential care was higher than the rates of COVID-19 deaths of adults with learning disabilities generally

- Many people with learning disabilities have difficulty accessing healthcare in ordinary times and are likely to have had more difficulty negotiating the new ways to do this if needed. All these factors suggest people with learning disabilities are likely to have been more vulnerable than others in the various stages of the COVID-19 pandemic

National Learning Disabilities Mortality Review Programme ((also called 'LeDeR') COVID-19 report highlighted:

- Identifying deterioration in Health
- In appropriate use of Did Not Resuscitate (DNAR) Forms
- Diagnostic overshadowing
- Not enough reasonable adjustment is made
- Did not Attend (DNA) learning disability check appointment in the year before death

[10] Public Health England (2020) Deaths of people identified as having learning disabilities with COVID-19 in England in the spring of 2020.

Learning Disability Programme Plan

What progress have we made so far?

Some examples of progress made in recent years include:

- More adults with learning disabilities are now in employment opportunities (including volunteering, internships, apprenticeships and paid employment).
- Almost 78% of adults with learning disabilities are living in their own home or with family. This is an increase from 2016/17 when the figure was 71%.
- There are now fewer inpatients with learning disabilities going into specialist hospitals and mental health units.
- The NHS England funded health facilitation project has enabled primary care to increase the number of people on the learning disability register from 994 in 2019 to 1040 in 2020; this will provide the foundation for ensuring a continued focus on addressing health inequalities.

What do we plan to do next?

Person-centred care

- Review and redesign how services for people with learning disabilities are commissioned and delivered across health and social care to provide a consistent offer.

Living in a place called home

- Provide people good and affordable accommodation, within their local community, which is designed to meet individual needs and offers good value for money
- Reduce the number of people who are living in residential/nursing care
- Improve information and advice regarding housing options
- Ensure that young people with learning disabilities can move into adult living with a clear plan and support to enable independent living
- Review all out of borough placements, working to support people to remain in-borough and only placing people in accommodation that is outside of the area if this meets their needs or this is what the person has requested

Receiving the right support and being part of the community

- Review the day opportunities provision in Sutton, implementing learning from some of the innovations developed during the Covid-19 pandemic
- Continue to improve the pathways for young people approaching adulthood with a new policy framework
- Implement a new Training and Development Strategy that will support staff to deliver seamless person-centred support
- Review the community provision of Changing Places toilet facilities.

Health and healthcare

- Ensure that there is greater awareness about Covid-19 in the learning disability community; including precautions that can be taken, vaccinations, symptoms to look out for and how to get help.
- Standardise equity of access to care and equality of outcomes across Primary Care Network (PCN) populations
- Develop clearer and more integrated pathways for people to access appropriate health services
- Continue to learn from Learning Disability Mortality Reviews to make changes to improve services

Planned activities for 2022/23

Person-centred care

- Integrate outcome-based indicators in health and social care contracts
- Progress work to review and redesign how services for people with learning disabilities are commissioned and delivered across health and social care to provide a consistent offer
- Progress work to identify how universal services can better meet the needs of people with a learning disability and ensure training is available to support this

Living in a place called home

- Develop and implement a new Accommodation Strategy for people with a Learning Disability
- Review 50% of out of borough placements to see if their needs could be better supported by returning to Sutton if they want.

Receiving the right support and being part of the community

- Pilot a learning disability single point of access for community services.
- Continue work to develop opportunities for people with learning disabilities to be active in the community.
- Continue work to expand respite and short break options for people with a learning disability.

Health and healthcare

- Implement the NHS England funded Exemplar Annual Health Check Project
- Implement integrated pathways for learning disability and mental health specialist services
- All GP practices prioritise people with a learning disability patients who are 14 -17 years old, people living with learning disability living in deprived areas; black, Asian and minority communities for an annual health check
- Develop cancer screening promotion video for people with learning disabilities

How do we know we are making a difference?

- Increase the % of adults with a learning disability who live in their own home or with their family
- Increase the % of adults with learning disabilities in employment opportunities
- Increase the % of people with a learning disability who have had an annual health check
- Other relevant indicators to be developed subject to agreement to the new joint Learning Disability Strategy and its priorities

What difference will this make to people in Sutton?

The following 'I-statements' form the basis of the new Learning Disability Strategy. We will keep these ambitions at the forefront of our work, to ensure we are making real a difference to people with learning disabilities in Sutton:

- Person-centred care means: "I am able to tell people what I like and what I want to do"
- Living in a place called home means: "I am part of my community; I feel safe in my environment, wherever that is."
- Receiving the right support and being part of the community means: "I have choice about what I would like to do"
- Good health and health services means: "I am as healthy as I can be, and get all the support I need to stay healthy"

Some examples of local initiatives that are addressing health inequalities for people with learning disabilities are the Sutton Health and Care Learning Disability Facilitation Project and Nickel Support learning disabilities service creating employment for people with learning disabilities

Nickel Support provides a local example of creating employment opportunities for adults with learning disabilities.

A major inequality is the ability to secure and maintain gainful employment as people with learning disabilities are more likely to be excluded from the workplace than any other group of disabled people. This may be due to a lack of work readiness, poor communications skills, loss of benefits as well as a lack of understanding and willingness on the part of the employer.

Spotlight on Charlie's Blog Post at Nickel Support

We have been talking to trainee Charlie about her time at Nickel. Charlie started with us 6 years ago. As well as doing sessions in our community shop (Interestingly Different) she also does Upcycling and Social media sessions. Charlie is one of our trainees who is in paid employment, who has been employed through the profits generated from our social enterprises. Before joining Nickel, Charlie struggled with confidence in communicating with other people and would rather spend time alone and at home. Going to the shops on her own and speaking to other people seemed like a real challenge that she would usually avoid. Since joining she has really grown in confidence and will now happily talk to a range of different people.

Through her work at Interestingly Different, Charlie has learnt a range of skills including dealing with customers queries, listing and managing stock online, and taking cash/card payments. Her knowledge of furniture has really improved, as has her terminology when writing item descriptions. However, one of the biggest skills for her personally has been the building of confidence in talking to people and learning how to adapt the way she talks depending on who she is speaking to. This applies to Nickel trainees, customers, staff, and general members of the public. When she started, she was reluctant to talk to anyone but now she willingly makes an effort to chat to everyone and get to know a bit more about them.

When asked what she likes about Nickel Support she responded. "It pushes me out of my comfort zone, and they support me to do things I wouldn't or couldn't do before, like answering the phone for example. They support me and guide me when I'm struggling with something. It feels good when I achieve something I didn't think I could do and encourages me to do other things. I feel proud of myself when I do something I wasn't able to do before." Speaking of a time when Charlie realised Nickel was really helping her grow, she replied. "When I realised, I had the self-belief and confidence to do things myself in the shop without being told how to do it"

Charlie has learnt and grown so much so that she now is able to manage the shop on her own when the manager is out on deliveries. Alongside supporting Charlie with developing her employment and relationship skills we have done work with her to improve her health.

"Nickel has supported me in learning to make better food choices and encouraged me to batch cook my meals so I can have healthy lunches for the week. To prevent me from grabbing food from the bakery or making unhealthy choices. They have helped me think more about what I eat and I have realised how it affects how I feel"

Like many of us Charlie occasionally has 'off days' and feels like she just wants to be at home sometimes. But Nickel gives her somewhere to be and gets her out.

"I've learnt that staying home will have an impact on my employment, so I force myself to come into work and I know I feel better. I know being around other people and bouncing off their energy helps and there's always people to talk to if I have any worries. The staff have always been there and made it known I can always come and chat about anything if I need to. If I ever have a bit of an off day, I know I have people outside my family to speak too."

She describes Nickel as "It's like having a second family. You know that no matter what, they are going to be there for you"

We are so proud of Charlie and how far she has come since starting Nickel. Not only has she grown so much herself, she is now helping other trainees do the same. Taking the time to chat to them and teach them the skills she has learnt. Her passion for working in the shop and the pride she takes in managing the Etsy shop is clear to see. We look forward to seeing what else she is capable of in the future.

To find out more about Nickel Support and the work they do visit their website www.nickel.org.uk

Making a difference

Sutton Health and Care Learning Disability Health Facilitation Project

There are 23 GP Practices and 4 Primary Care Networks in Sutton with over >1000 people on the learning disability register. The Learning Disability Health Facilitation Project aims to support early identification of people with learning disabilities on GP Practice register who either do not respond to invitations for their annual health check or do not attend their health check appointment when a time is arranged. **In Sept 2021, Sutton was awarded NHS England Learning Disability exemplar funding for the London region based on the results of the 6 months pilot that started in January 2021.**

Key objectives:

- Target and offer Annual Health Checks to patients that Did Not Attend (DNA), non-responders and those who require home visits
- Tailor and support practices with making reasonable adjustments for people who are hard to engage.
- In-reach into supported living to support individuals who are living independently
- Continue to capture patient experience through Speak up Sutton Advocacy Group
- Improve quality of Health Action Plan through training of practice staff
- Ensure that Health Action Plans evolve into more personalised care plan for people with a learning disability GP register

Case Study Profile	• **53 year old female with mild learning disability who received a Learning Disability Annual Health Check in March 2021** • Was a care assistant in a nursing home pre - COVID • Recently unemployed and shielding (March 2020) • Full time carer for her husband with dementia
Presenting conditions	• Mild confusion • Delay in comprehending speech • BMI 34.2kg/m2, obese and broken teeth • Leicester diabetes screening score 27-very high risk • Tearfulness, social isolation • Physical abuse experienced from husband secondary to his dementia • Unable to meet self-care needs and carer burn out • Financial issues - piling up of unpaid bills • Stress from upcoming house move
Problems we addressed	• Urinary tract infection, confusion, social isolation, physical abuse from husband, financial issues and carer burn out
What we did	• GP prescribed antibiotics and booked review in 1 week • Referred to Sutton Uplift for mental and wellbeing support • Referred to social prescribing • Contacted domestic victim support for advice and referred. • Contacted safeguarding team for advice • Referred to Learning Disability social services • Admiral nurse contacted for support • Referred to Social Services for carers assessment
What the patient did	• Copy of Health Action Plan given to patient. • Advised patient to book optician and dentist • Gave a simple healthy eating and exercise advice for promoting weight loss

Health and Care Integration Programme

Background

The health and care integration programme provides the framework for joining up local services to improve the health, wellbeing and experiences of individuals, through both local transformation programmes. Around £22.3M NHS SWL CCG (Sutton) and Sutton Council Better Care Fund is supporting integration of community services, Homefirst in-reach into St Helier Hospital, community learning disability service, reablement and carers support.

We are developing new ways of working which necessitates service integration and greater coordination between community services and primary care networks at neighbourhood levels and therefore a deeper process of organisational and people development is needed. We want to work with frontline staff and local leaders to provide care across organisational boundaries operating as one blended and /or integrated team. This programme provides the framework that supports the local system to successfully deliver the integration of health and social care in a way that supports person-centred care, sustainability and better outcomes for people and Carers and keeps well and out of hospital.

Workforce

Like most areas Sutton is facing its fair share of recruitment and retention changes of frontline workers. These challenges will be addressed regionally within the context of the south west London system and locally collectively as a health and care system. We are working together to develop an immediate plan to support delivery of services throughout the winter months.

Shared Clinical System by GP Practices and Sutton Health and Care Community Service

Sutton Community Services are operated through partnership arrangements in Sutton, through Sutton Health and Care. There is commitment to move local community services from existing clinical system to EMIS which is the preferred clinical system for GP Practices in Sutton This will further optimise patient care, integrated working and transformation of community services through technology.

The benefits of the community services using the same platform as primary care enable include:

- real time (within seconds) data sharing between community and primary case within Sutton
- a full capability to book cross organisation or services appointments and make cross organisation or services referrals within Sutton.
- all reporting can be undertaken against a single dataset across primary and community care within Sutton.

Health and Social Care Integration Journey

We are making progress towards integrated health and social care functions working arrangement for operational teams. The Wallington proof of concept is testing the redesign the within the locality is developing a model of aligned and integrated working that can be expanded across the other Sutton localities. Ultimately, this project will deliver a standard operating model that creates support within the community for everyone through a single function, including supporting self-management and self-care in the community to support people and their carers to remain living healthily and independently.

Implementing joint assessments and care planning to prevent admissions that will include family and carers being involved in the decision making. Training to identify how health and wider inequalities affect population groups, individuals, and their carers to find solutions that help to mitigate their risk of admission.

Move towards primary care networks and community neighbourhood teams

A new operating model of primary care networks and community neighbourhood team will support local delivery of wider range of services to patients whilst considering health of the wider population; taking a proactive approach to managing population health and assessing the needs of the local population or neighbourhood to identify people who would benefit from targeted, proactive support.

The neighbourhood teams will manage the majority of care of patients in the community. This means that local health and care services will be shaped based on population health needs and insight from residents and patients. The work of the neighbourhood teams will be coordinated by a core leadership group of senior professionals from the PCN, Sutton Health and Care, London Borough Sutton Adult Social Care and SWL & St George's Mental Health Trust who will be responsible for the operational coordination of services and local response for PCN populations and / or sub-populations.

The model builds on and formalises the primary care networks Community Response Team (CRT) arrangement. CRTs have become the building block for the delivery of personalised care for individuals, carers and families and innovation such as the Sutton Community Virtual Ward. It is evolving into the framework for managing population health needs and health inequalities through integrated working arrangements between community services and the PCNs

Health and Care Integration Programme Plan

What progress have we made so far?
• Our PCN Community Response Teams (CRTs) multidisciplinary model have been established to support multiagency response to the needs of individuals and families with complex needs who may have been disadvantaged, suffer from economic deprivation or whose situation may have been exacerbated by the pandemic. CRTs has representation from Sutton primary care networks (PCNs), Sutton Council, Sutton Health and Care Community Services, Charities and voluntary sector organisations. It is these CRTs we now wish to build upon to create our enhanced collaborative leadership model integrated around PCNs. • The Wallington integration project began in 2019 with co-located health and social care teams at Wallington Library but was suspended during the COVID-19 pandemic. There is senior-level support across all functions to implement the next steps quickly and initial discussions on the way forward have already taken place. The appointment of a joint Head of Service for Health and Social Care will build on recent joint service improvements developed during the pandemic. For both partners, this represents an opportunity for a meaningful realignment to joint management in health and social care, which ensures the project moves forward at pace and offers a reduction in overall management overheads across the system while addressing the requirements in the Health and Care Bill • Proposal and consultation on developing Primary Care Networks and Community Neighbourhood Teams has been completed.
What do we plan to do next?
Approval and implementation plan for the new PCN and Community Services Neighbourhood Teams model.
Planned activities for 2022/23
We are still developing additional planned activities around estate, workforce and Information Technology (EMIS) and the PCN and Community Services Neighbourhood Teams.
How do we know we are making a difference?
We will define measures that will allow us to monitor if we are making a difference. These will include as a minimum for example: • The number of people receiving care from new models of integrated primary care networks and community services neighbourhood teams
What difference will this make to people in Sutton?
• Residents will be better able to prevent crisis and unnecessary visits to hospital, avoidable admissions or lengthy stays in hospital. • Resident will have access to the right treatment in a timely way to stabilise their condition and manage their needs.

Sutton Health and Care HomeFirst +case study is a local example of innovative practice that is transforming patient care in Sutton

Making a difference

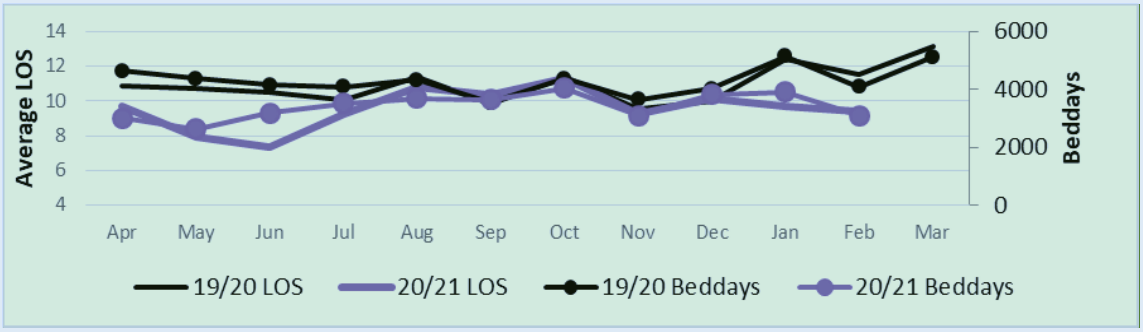
Sutton Health and Care (SHC) Home First+ Service – Integrated Discharge to Assess Model (partnership between Sutton Council Adult Social Care, Sutton Health and Care HomeFirst+ and NHS Sutton Continuing Healthcare).

Sutton Health and Care (SHC) Home First+ (HF+) services were established in 2020 as the key vehicle for our integrated coordinated discharge model. The service focused on those people at most risk of emergency hospital admission. Its ambition was to impact upon these people's care through improved coordination of services and specialist support to prevent the need for an emergency admission or to reduce the length of time a person needed to stay in hospital following an emergency admission.

Under the COVID-19 Discharge to Assess Model, the service brings together SHC, social care and continuing health care functions into an integrated team, coordinating health and care support for patients medically optimised for discharge from hospital. The successes achieved to date are outlined below

Key achievements:

- Sutton Council Adult Social Care, NHS Sutton Continuing Health Care and Sutton Health and Care HomeFirst Services collaborated to establish the Epsom and St Helier University Hospitals NHS Trust discharge and assessment hub that supported over 250 patient discharges during a 6-week period to release over 100 hospital beds at the peak of the pandemic
- Superstrated numbers have shown significant improvement
- More than 80 % patients stay in their home after 91 days of the discharge to assess programme first appointment
- Reduced readmissions rate within 7 days of discharge at St Helier Hospital
- Overnight admissions of over 65 years olds are showing year on year reduction improvement
- Average Length of Stay (LOS) in days and numbers of beds for patients has shown significant improvement

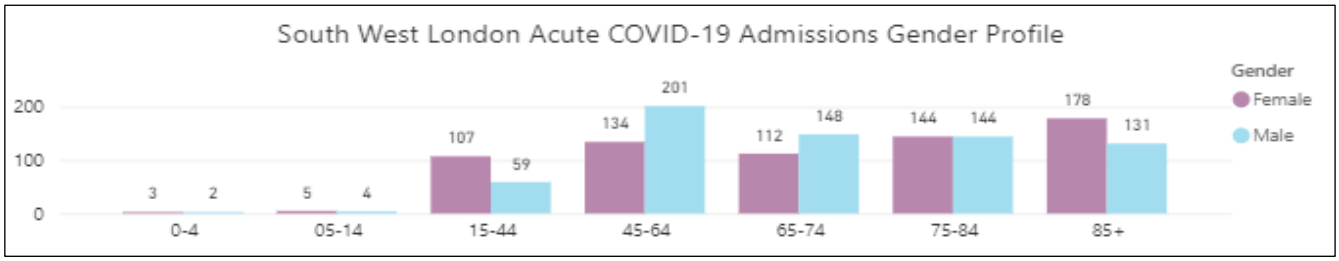


Health Inequalities and Population Health Programme

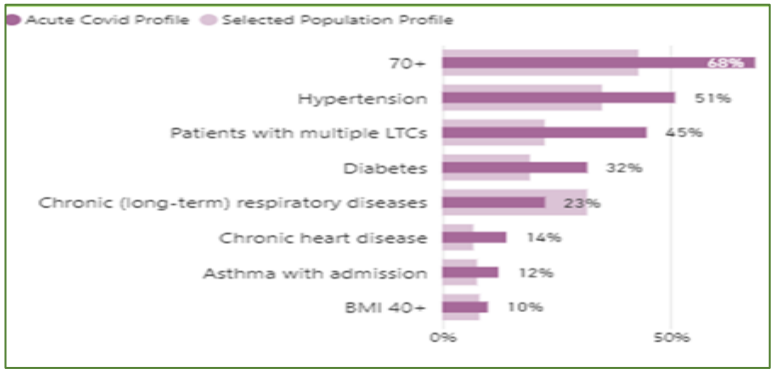
The Health Inequalities and Population Health Sub-group of the Integrated Partnership Board has been established to provide leadership and co-ordination for reducing health inequalities and improving health and wellbeing across Sutton. This will be achieved by bringing together stakeholders from the communities, Charities and Voluntary Sector, NHS and Council to plan and deliver actions and services.

Profile of Sutton's COVID positive patient hospital admissions

Around **1372**[11] Sutton registered patients have been admitted with a COVID positive status. With White ethnicity presenting with highest level of COVID related acute admission.



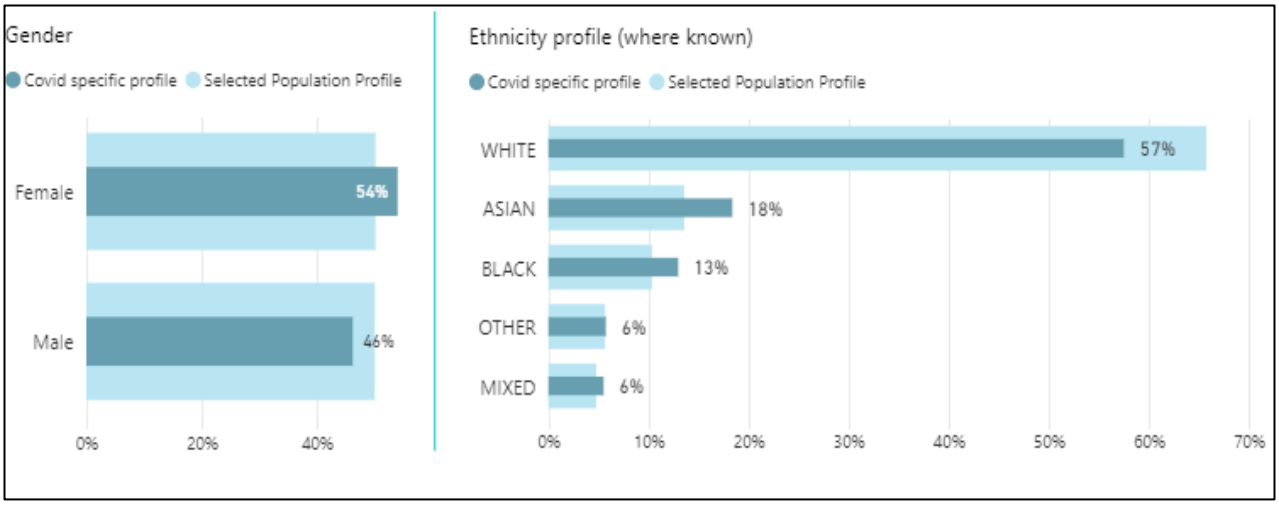
Patients admitted with COVID are typically over 70 years old, have high prevalence of hypertension, multiple long term conditions, diabetes, chronic heart disease, asthma and BMI 40+ when compared with SWL population. Patients who were admitted with COVID were already known to community services.



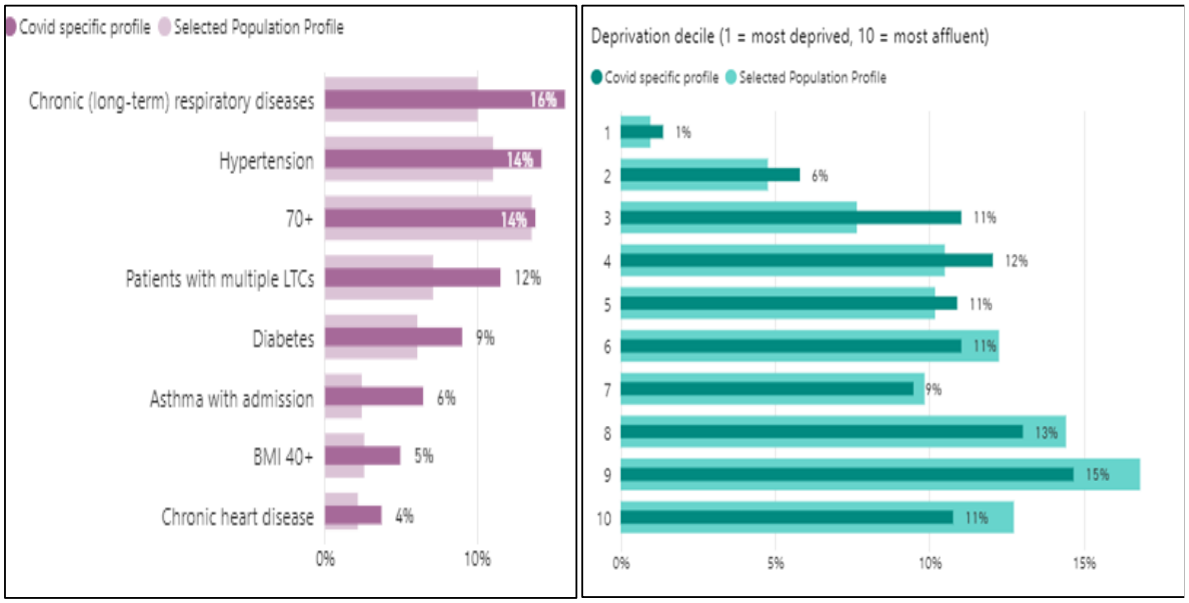
Profile of NHS 111 suspected COVID-19 positive callers

NHS 111 suspected COVID-19 positive callers are people with underlying chronic respiratory disease, hypertension, over 70s, multiple long term disease, chronic heart disease and asthma with admission and BMI 40+. Typically female, predominantly Asian and black when compared to south west London patients' population.

[11] 11th Sept 2021. Live data from SWL CCG/NEL CSU Analytic team



Callers to NHS 111 are already known to mental health services including Improving Access to Psychological Therapies and community services. NHS 111 callers with COVID -19 live in the most deprived areas of Sutton.



Making a difference

Sutton Blood Pressure Monitor @ Home Project

Sutton is participating in the BP@Home project which aims to support early detection of heart attacks and strokes associated with high BP. At risk patients from black, Asian and minority ethnic groups and over 60 year olds are being targeted.

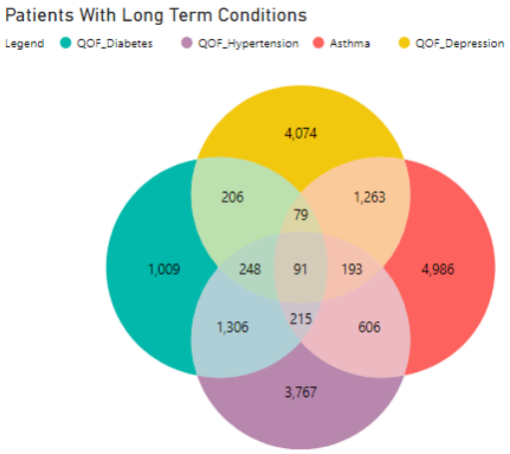
Sutton PCNs Long Term Conditions Profile

Around 33% of the 207,098 patients registered with Sutton GP Practices have multiple long term conditions with high prevalence in cardiovascular diseases (such as hypertension, atrial fibrillation, coronary and heart disease), diabetes, depression, epilepsy and learning disability when compared with south west London GP Practice population.

St Helier, Wandle Valley and Beddington South have poorer health and wellbeing in comparison to Sutton. There are **higher rates of alcohol-related conditions**. Patterns of poorer health start young, **with higher rates of obesity amongst ten year olds**, and continue into adulthood, with fewer adults taking part in enough physical activity.

All this will make them more likely to suffer poorer health and wellbeing.

Carshalton PCN



34% of the PCN population have one or registered long term condition. 52% of the population predominantly **lives in areas categorised as more deprived compared to 28% in Sutton overall and 36% in SWL.** The most prevalent long term conditions are:

- Hypertension – 12% of the population
- Depression – 12% of the population
- Asthma – 11% of the population
- Diabetes – 6% of the population

Disproportionately more patients have multiple long term conditions. 12.6% within Carshalton vs 9.6% at SWL level. In contrast, Carshalton's population with one or more long term condition has 4% more patients in the least likely to be admitted group, based on admission risk stratification. The rate of admission for people with diabetes is 4 times higher than the general population

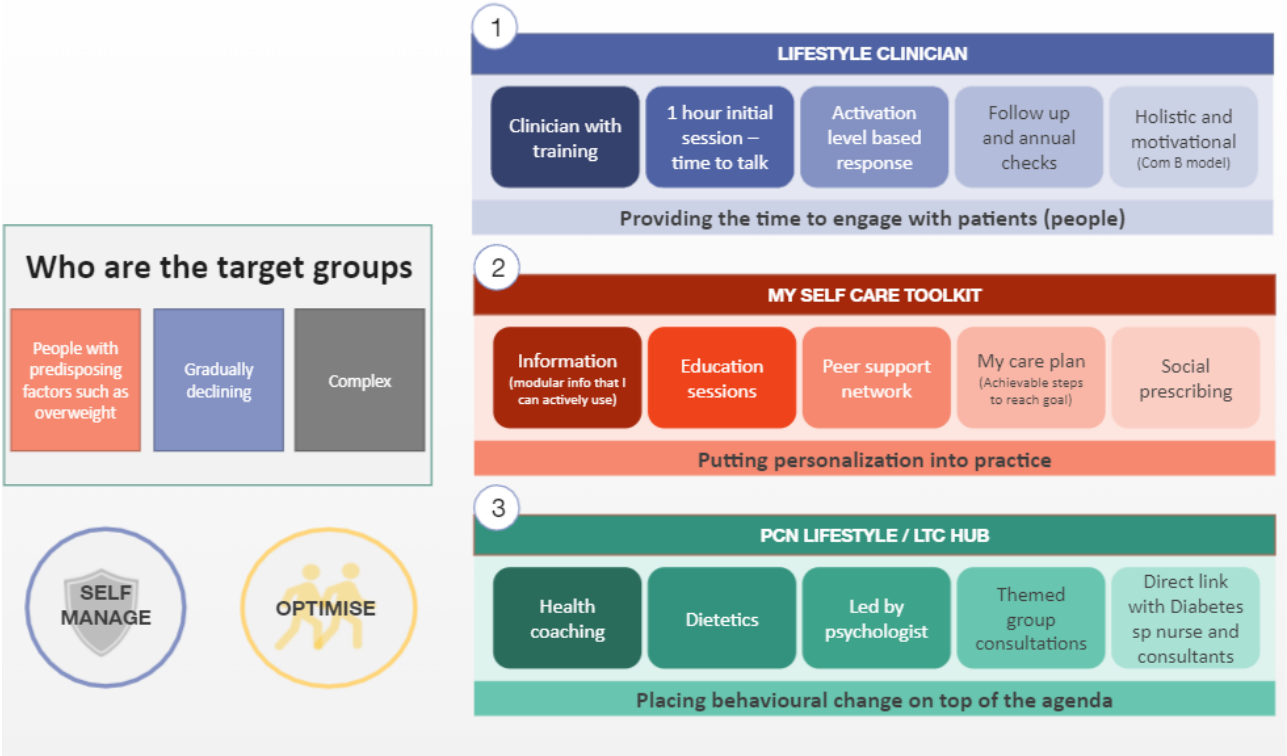
Carshalton PCN Diabetes Project. Carshalton PCN is now in the delivery phase of the Diabetes Project which aims to improve the outcomes for people with diabetes and long term conditions including identification of interventions to reduce health inequalities. Figure 6, proposed model of care is included below. There is an undiagnosed population of diabetics, likely to be difficult to engage, between 40 and 64 and predominantly white from deprived backgrounds and potentially overweight.

Patients with diabetes are 2.5 times more likely to attend a GP appointment or being admitted to hospital (7.91 per Carshalton PCN diabetic patient/3.22 per Carshalton PCN non-diabetic patient)

In 2019/20, 11,444 people aged 17+ were recorded with diabetes across the Sutton Borough, 6.9% of the population. In Carshalton PCN, the prevalence of obesity is rising year on year. In 2019/20, 10.7% of the 18+ population were obese (BMI 30>. 49% of diabetic patients within the PCN are classed as obese and 34% classed as overweight.

The Carshalton PCN GP registered patients predominantly reside in the Wandle Valley, The Wrythe and St Helier wards. St Helier has one of the highest rate of obesity, depression and diabetes which places the residents in the high-risk category for COVID-19 and highest hospital stays in the borough for alcohol related harm.

Figure 6: Carshalton PCN Diabetes Model of Care



St Helier Putting People First Project ambition is to prove the concept of securing positive outcomes in a defined place, using a community hub and integrated service development and delivery framework. The project aims to establish a place based integrated service development and delivery offer that will improve the health and well-being of the population of St Helier in line with other Sutton wards.

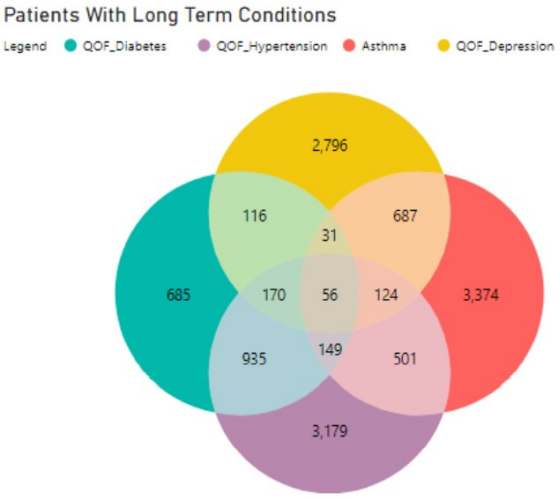
St Helier is an area of deprivation in Sutton, but previous regeneration projects and targeted interventions have failed to materialise into long lasting and sustainable change. Data suggests that only 8% of people feel that they are able to influence decisions about what matters to them.

Central Sutton PCN Health Profile

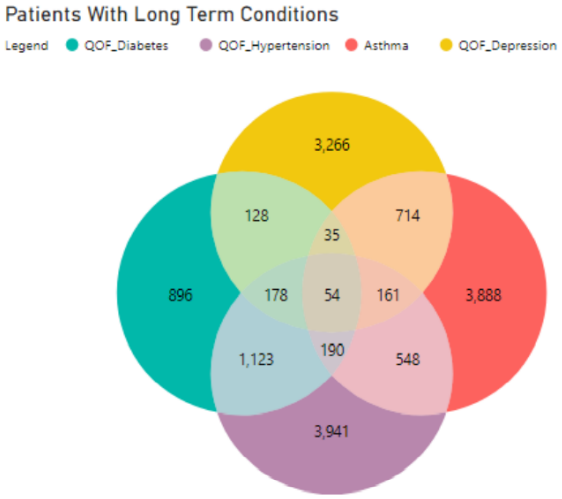
30% of the population have one or registered long term condition. Majority of the population predominantly **live in areas categorised as least deprived when compared** to the rest of Sutton. The most prevalent long term conditions are:

- Depression – 10% of the population
- Hypertension – 11% of the population
- Asthma – 9% of the population
- Diabetes – 5% of the population

Disproportionately more patients have multiple Long Term Conditions. 11.2% within Central Sutton vs 9.6% at SWL level.



Cheam and South Sutton PCN



33% of the population have one or registered long term condition. It is **a highly affluent population, 90% live in areas categorised as least deprived** compared to 72% in Sutton overall and 64% in SWL. The most prevalent long term conditions are:

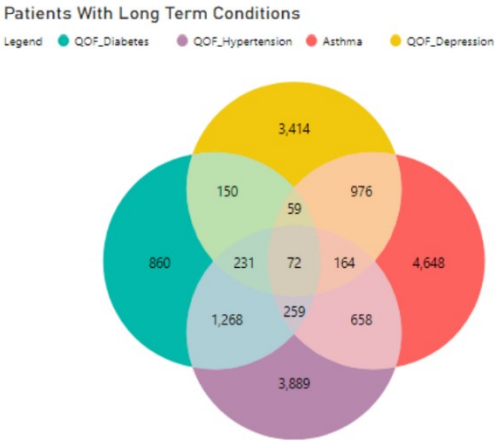
- Hypertension – 13% of the population
- Depression – 11% of the population
- Asthma – 10% of the population
- Diabetes – 5% of the population

Disproportionately more patients have multiple long term conditions. 12.3% within Cheam and South Sutton vs 9.6% at SWL level.

Wallington PCN

34% of the population have one or more registered long term condition. **Although 75% live in areas categorised as least deprived, there is a significant proportion - 9% that live in areas of deciles 1 and 2, which are the most deprived**. The most prevalent long term conditions are:

- Hypertension – 13% of the population
- Depression – 11% of the population
- Asthma – 11% of the population
- Diabetes – 6% of the population



Disproportionately more patients have multiple long term conditions. 12.7% within Wallington vs 9.6% at SWL level.

Roundshaw Whole System Healthy Weight Pilot aims to improve the long-term health and well-being of the population of Roundshaw estate in Wallington by creating an environment in which social determinants of health are improved and are conducive to forming large scale sustainable healthy habit change – "making the healthy choice the easy choice". The pilot project will run from 1 April 2021 to 31st March 2022 with plan to develop a community based whole systems approach which is scalable and applicable to other areas across south west London.

Obesity is also an inequalities problem where obesity rates are doubled in the poorest communities. The pilot will adopt the Public Health England's Whole systems approach to obesity (2019). This pilot will utilise Public Health England's whole systems framework to focus on sustainable healthy habit creation around 5 key elements: nutrition, movement, sleep, stress management and personal environment modification

In Sutton, obesity is framed as an overarching risk factor for developing long term conditions. It is responsible for 80-85% of someone's risk for developing Type 2 Diabetes Mellitus. Linked to COVID -19, under age 55 obesity identified as most important risk factor for developing complications leading to hospitalisation

Obesity in children is a precursor for obesity as an adult. 1 in 4 10 year olds in Carshalton PCN are obese. 17% of children within the Carshalton PCN area aged 0 - 15 live in low income households below the poverty line where access to healthy foods may be problematic.

Wallington Primary Academy Roundshaw Project (now referred to as the Roundshaw Approach) project aims to develop community wide response to improve outcomes for children and young people and families living in Roundshaw, Beddington South Ward. Population and behavioural insights for the project highlight the following:

- 28.7% children in poverty (highest in the Borough - 2015)
- 21% with no qualifications
- 20.5% children obese in Year 6
- Highest hospital stays for self-harm
- General mistrust in services, lack of attendance in education and Did Not Attend (DNA) to appointments
- Poor dental care, obesity and mental and emotional health needs
- Medication misuse and drugs

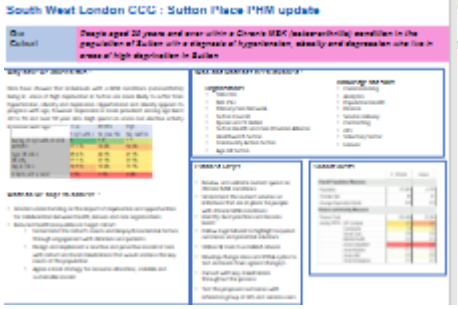
Sutton Place Population Health Management Approach

Sutton is the NHS South West London Clinical Commissioning Group borough pilot site for the NHS England and Optum population health management approach. Following population data review by Sutton leaders and input from local health and care professionals; it was decided that the Sutton Place pilot will focus on people aged 20 years and over with chronic musculoskeletal (osteoarthritis) condition, diagnosis of hypertension, obesity and depression who live in areas of high deprivation in Sutton. The model of care and outcomes are being developed and will be tested with a representative sample of the patient cohort.

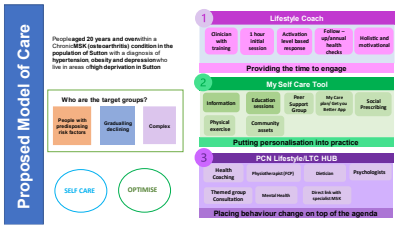
Figure 7: Snapshot of output from Sutton Place Population Health Management Action Learning Set

Analytics (population size, LTC, areas of deprivation)

Cohort segmentation

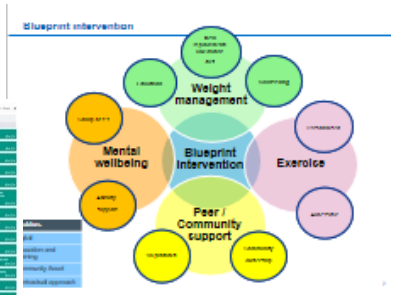


Review of existing services



Model of care (based on Carshalton model)

LOGIC Model (outcomes, outputs and activities)



Proposed blueprint interventions

Health Inequalities and Population Health Programme Plan

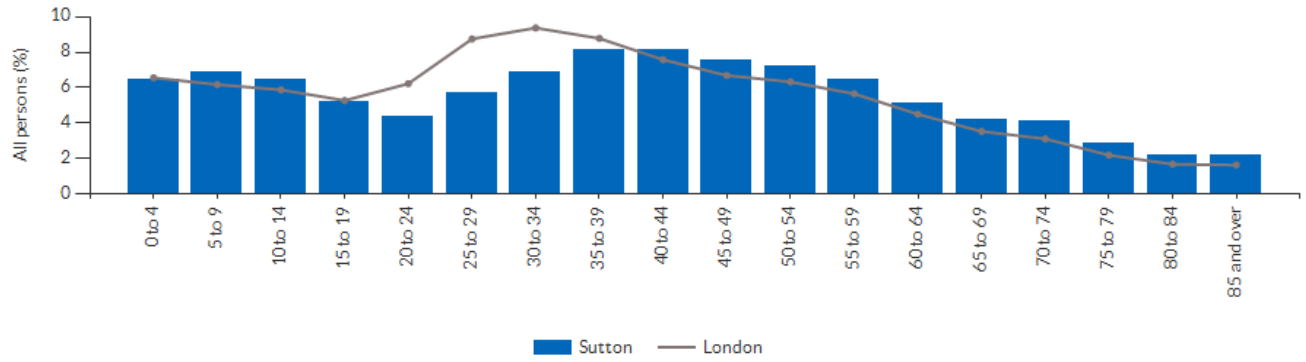
What progress have we made so far?
• The Health Inequalities and Population Health Sub Group of the Integrated ICP Board has been established with first meeting held on 19th October with development session with external speakers from Morecambe Bay and North Surrey to share their experience. This Group is led by the London Borough of Sutton Director of Public and PCN Clinical Lead for Population Health Management. • To tackle obesity, Wallington PCN, NHS England/Optum population health workshops are taking place to support the development of a model for obesity • We implemented a targeted COVID Vaccination Project to engage with unvaccinated population cohorts residing in wards with low vaccine uptake such as St Helier, Wandle Valley, Beddington South, Central Sutton and Belmont. • Moved to the delivery phase of the Carshalton PCN Diabetes project • Going through design phase of NHS England and Optum Population Health Management project for people with chronic MSK conditions (osteoarthritis) who often live in areas of high deprivation and are more likely to suffer from hypertension, obesity and depression
What do we plan to do next?
• Develop work programme for tackling heath inequalities in Sutton co-produced with stakeholders and communities • Establish regular Health Inequalities and Population Health Management Board monthly meetings and additional Board and wider reference group meeting • Implement the Wallington Primary Academy project, St Helier Ward Project and expanded model for social prescribing • Evaluation of the Roundshaw Whole System Healthy Weight Pilot and Carshalton PCN Diabetes model to inform spreading and scaling at Place • Explore the concept of PCN neighbourhood and wellbeing hubs and health campuses
Planned activities for 2022/23
Planned activities will include as a minimum: • Develop detailed work programme for the Health Inequalities and Population Health Management Programme Board that includes communication and engagement approach that will be co-produced with communities and reflect agreed narrative by all partners • Deliver the St Helier Project and expanded model for social prescribing • Implement the Carshalton Diabetes, Wallington Obesity and MSK Osteoarthritis model of care
How do we know we are making a difference?
We will work with communities to co-design and produce measures that will allow us to monitor if we are making a difference
What difference will this make to people in Sutton?
Diabetes • Increased self-care by people with Type 2 Diabetes evidenced by reduction in GP attendances Obesity • Resident's report feeling more in control of their health and well-being. • Residents report an increase of quality of life and community engagement.

Age Well

Background

Sutton's Population is predicted to rise from 206,075 in 2020 to 213,805 by 2030 with projected increase expected in residents aged 40 to 85 when compared with London. Older people aged 65 years and over make up 13% of the Sutton population and residents aged 85 years and over make up 2.2%.

Figure 8: Sutton's population growth projections



Date: 2020 Source: GLA

Age Well focuses on empowering older people to look after their own health and wellbeing through participation in on preventative activities. It aims to deliver integrated high quality personalised care that addresses the needs of older people when they are unwell or at risk of hospital admission. Sutton partners are committed to ensuring that older people keep their independence and take an active role in their own care by giving a voice to our older generations.

Themes underpinning Age Well include the following:

- Prevention and Well-being Approach
- Tackling social isolation in older people
- Support people with frailty related conditions to live independent and healthy lives

Update on commitment in the 2019 Plan

Traffic light system – red outstanding, green- completed and amber in progress

1. Work with residents, community groups and businesses to investigate ways to leverage community capacity to better support people to be physically, economically and socially active	A
2. Extend the provision of social prescribing through voluntary sector organisations within Sutton	G
3. Extend the development of our Sutton Health and Care programme through a proactive model of care	G
4. Further integrate pathways across Sutton Health and Care At Home service	G
5. Redesign the falls model	A
6. Expand delivery of the Sutton End of Life care model for individuals in the last 12 months of life	G
7. Progress the working together functional review for delivery of continuing healthcare	A

The 2022- 24 outcomes for Age Well are:

- People die in the Preferred Place of Death and improved coordination of care in the last year of life and support to carers
- By providing the most effective access to emergency care and the best quality care, and by reducing pressure on emergency services, our local people can:
    - be better able to prevent crises and unnecessary visits to hospital, avoidable admissions or lengthy stays in hospital.
    - have access to the right treatment in a timely way to stabilise their condition and manage their needs

Prevention and Wellbeing Approach

In Sutton, there is commitment to support local residents to live and age well, and this means addressing the causes of poor health and embedding a culture of prevention across the health and care programmes. Local partners recognise the impact of both physical and mental health in maintaining our wellbeing. There is commitment to support people to sustain or improve their wellbeing in later life. Staying as healthy as possible, mentally and physically, is an important part of this. But non-clinical issues, such as poverty or loneliness, are also key. Taking action early can help reduce and even prevent poor mental and physical health

The local health and care plan describes commitment to establish health and wellbeing neighbourhoods starting with the Wallington Health and Wellbeing Hub Proof of Concept. The wellbeing hubs will support local residents to access physical and digital community assets that have been co-produced with local residents and voluntary sector organisations.

There is growing evidence to suggest that person and community centred approaches such as social prescribing improve the health and wellbeing of individuals and their communities and can in the longer-term help reduce demand for health and social care services. The Sutton Social Prescribing Service is established and making a difference in the lives of people accessing primary care and community services. For these initiatives to be effective they must transform both culture and practice; and this requires strong collaboration and leadership. As a system, we recognise the importance of listening to older people on issues and barriers to accessing from wellbeing and communities. The Sutton Community Voice initiative will ensure that the voice of communities and local residents inform decisions about service provision.

Tackling Social Isolation in Older People

Loneliness and social isolation can affect people at any stage of the life course. However, changes and transitions associated with ageing mean that older people can be particularly vulnerable as risk factors for loneliness and social isolation. Sutton local population data indicate that residents living in certain parts of the Borough such as Wandle Valley are most at risk of loneliness. Data shows strong correlation between areas of high deprivation and risk of loneliness. For example, Cheam and South Sutton primary care network has the highest number of older people aged 65 years and over in Sutton, many of whom live alone in houses and flats without any social support. The level of social isolation has been exacerbated by the Covid-19 pandemic when many of the local charity groups stopped meeting face to face. Some older people do not have access to technology or are not able to learn how to access virtual platforms will feel more isolated from friends, family and health professionals. Cheam and South Sutton primary care network will work with local partners and older people to understand the needs of the older people who are isolated and what is

important to them. The primary care network will seek to engage local residents through community groups, residents' associations, faith groups, GP surgeries, the council and community services. Findings from the initiative will form the basis of future work to tackle social isolation in older people living in Sutton.

Frailty Programme

The NHS Long Term Plan sets out an evidence-based framework of care for older people with frailty to be delivered through the national Ageing Well programme:

- Community multidisciplinary teams - targets the moderate frailty population, people whose annual risk of urgent care utilisation, death and care home admission is 3 times that of an older person of the same age who is fit. This group are considered to be the most amenable to targeted proactive interventions to reduce frailty progression and unwarranted secondary care utilisation.

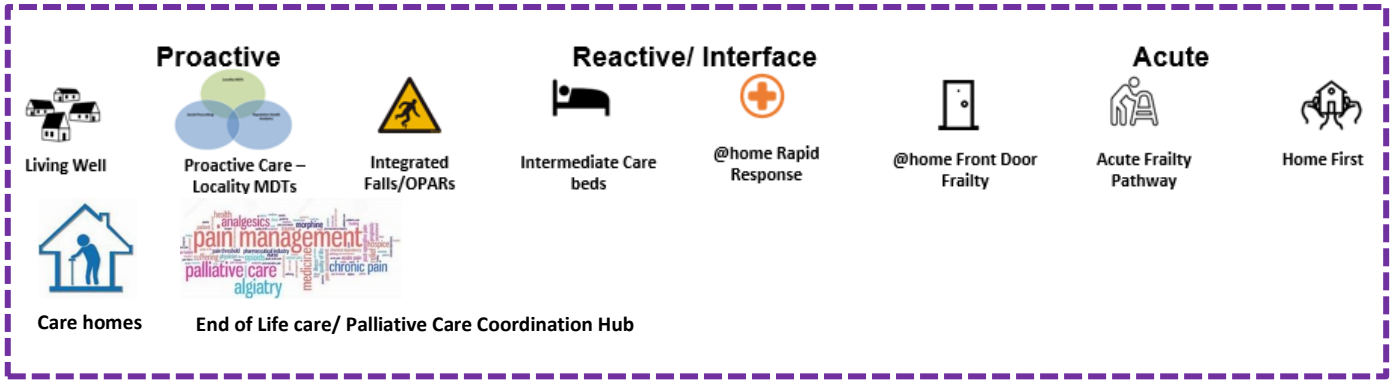
- Urgent Community Response – crisis response and community recovery for older people who are at risk of unwarranted stay in hospital admission and whose needs can be met more effectively in a community setting.

- Enhanced health in care homes (EHCH) – for which there is not a consistent health care support offer across England despite care home beds outnumbering NHS hospital beds and being an increasingly important place for end of life care.

The Age Well framework aim to support acute and community health services, social care and the voluntary sector to work together, turning what is currently urgent care into planned care for key groups of vulnerable older people

This programme seeks to bring together existing related projects under one umbrella in order to better coordinate and manage work being undertaken to support the frail elderly population of Sutton. This enables the development of a joined-up approach to care delivery. The aim is to:

- To have a consistent Sutton-wide approach to improving the care provided to people suffering from frailty
- Development of whole system pathways to support fluid transfer between settings
- Ensure a focus on maximizing service users independence and supporting people at home/ return home as soon as possible

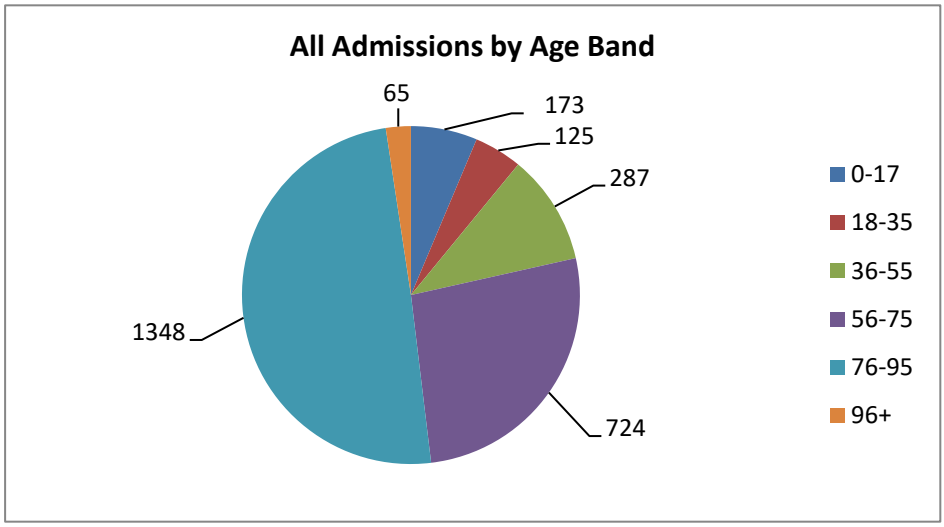


Key issues and challenge relating to frailty

- **Lack of identification of end of life care -** lack of identification of EOLC patients means wishes and preferences not known. Particularly social services frail patients for care packages

- **Increase demand for healthcare.** Sutton faces a significant future challenge as both the very young and the very old require more care. To cope with future demand the 2 -hour community urgent care response would need to integrate delivery across clinical pathways to reduce hand-offs and minimise duplication and move towards a single point of referral across delivery models by March 2022. People aged 75 years and over accounted for over 50% of the admissions related to clinical conditions that could potentially require urgent community response interventions

Figure 9: Increase in demand for community urgent care response by age band



- **London Ambulance Service** data shows Sutton care home incidents are higher during the day. There is an opportunity to enhance capacity to respond to urgent community crisis response in care homes.

- **Multiple entry points into Sutton community crisis response system - t**he national requirement is for <u>one single point of access</u> across areas. Pilot single point of referral for 2 hour response is being tested.

- **Local alignment** there needs to be alignment between local crisis response and the following:
  - Self-referral and carer referral
  - Proactive care – Community Virtual Ward supporting admission avoidance and transfers of care into community settings
  - Enhanced health in care homes – we are in the process of agreeing an urgent response pathway for Sutton Care Homes.

Discharge from Hospital

The Institute of Public Care review of HomeFirst referral pathway identified the following areas of improvement:

- More work needed to achieve a 'whole system approach' between the community and acute services
- Some discrepancy of discharge practice across different wards
- Increased capacity needed at the first point of contact to avoid unnecessary length of stay and to facilitate early discharge
- Need a common platform for information sharing and sharing or valuing the importance of information varies
- Useful to have a 'common language' so that everyone is clear what is meant and there is no risk of misunderstanding
- There are parallel integrated approaches, a 'front door approach' and a 'back door approach' into the community. It is unclear as to whether 'a push or pull model' from the hospital into the community operates
- Improved communication for patients, families and carers so that they are better informed and involved with the rapid discharge process
- The largest proportion of delays is a result of waiting for available suitable packages of care (POC).

Managing demand for emergency services and hospital beds through wider system collaboration

We have an emergency care system that is under real pressure. Sutton's wider health and care integrated working is focused on collaborative working between Sutton primary care networks, St Helier Hospital and Sutton Health and Care to understand and address preventable admissions and bring together practical examples, good practice and evidence-based advice across health and care, including housing and wider public services.

Our health and care partnership is looking to transform community urgent care services in our system, through a joined up approached between health and social care. We will work to ensure people receive the right care, in the right place, at the right time. We will look at innovative ways to reduce demand on acute hospital emergency services by helping people to more proactively manage their condition and access appropriate urgent care services closer to home, minimise unwarranted variation and maximise the value of every pound spent on urgent emergency care provision.

We will use the additional investment from the SWL Ageing Well Programme for Enhanced Health in Care Home, Virtual Ward and Anticipatory Care to transform how we provide out of hospital care to **improve r**esponsiveness of community health crisis response services delivered by Sutton Community Virtual Ward, Community services and At Home 2 hour community urgent care response, referral to the Palliative Care Coordination Hub to facilitate end of life care at home and additional intermediate care beds should put us in a good place for the winter months

This will help prevent unnecessary admissions to hospitals and residential care, as well as ensure a timely transfer from hospital to community. Intermediate health care packages will

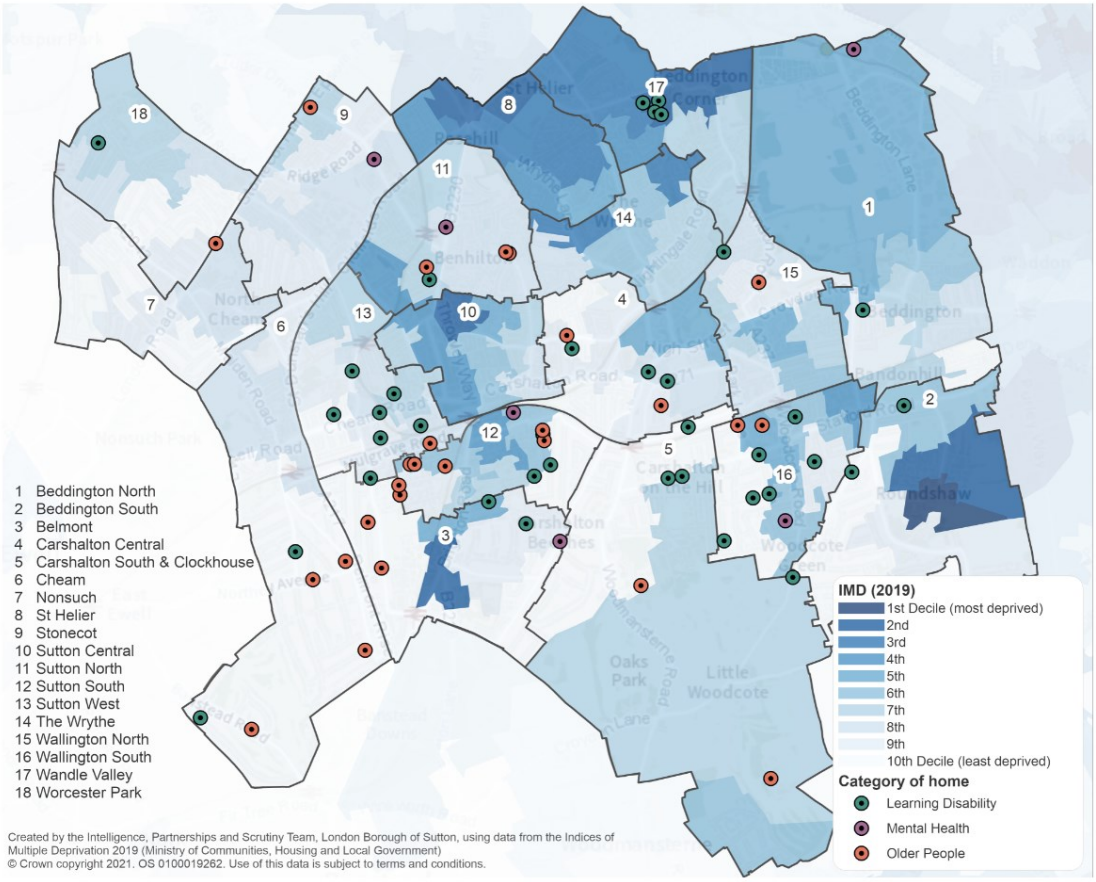
be delivered to support timely crisis care, with the ambition of freeing up hospital beds at St Helier Hospital

We want to do much more Admission Avoidance through the Virtual Ward to really shift the continuum away from admission to prevention. We know that the elderly, particular over 80s end up declining in independence and function following a hospital admission. Through stepping up support at home and remote monitoring which many of the elderly can be taught to do themselves, we optimise their medical management at home and also address any wider care needs.

Enhanced Health in Care Homes service

The Enhanced Health in Care Homes service offers care home resident in any of the 78 Sutton care homes a personalised care plan which includes a structured medication review (medication side effects being a high cause of hospital admission which can be avoided). The Sutton Care Home Support Team will include a Frailty nurse who will lead advanced care planning in the elderly and the team will also provide the care homes with training on oral hygiene and nutrition. In addition, the Restore2 training will start to be used as a marker for acute deterioration in care home residents and earlier intervention from care home staff. Action may involve calling an ambulance if appropriate but often it involves rapid response from the GP or care home support team in the first instance. Data will also be analysed to identify care homes and supported living with higher rates of ambulance call outs and hospital admission.

Figure 10: Overview of location of Sutton Care Homes



Source: Sutton Council

End of Life Care

The Sutton Joint End of Life Care Strategy 2020 -2023 ‘Living my Best Life to the End’ to deliver the standards described within the 'Ambitions for Palliative and End of Life Care: a national framework for local action 2015-2020’ which sets out six ambitions that focus not only on the experience of the dying person but also carers, families, those important to the dying person and, where appropriate, people who have been bereaved. With four workstreams identified - Identification, Advance Care Planning and Coordinate My Care (CMC); Equitable Access; Education and Training and Compassionate Communities

Frailty Programme Plan

What progress have we made so far?
• Developed integrated pathway for frailty that includes acute hospital and various health and social community services. The board provides strategic direction and oversees the implementation of the frailty pathway for Sutton. • Our PCN Community Response Teams (CRTs) multidisciplinary model have been established to support multiagency response to the needs of individuals and families with complex needs who may have been disadvantaged, suffer from economic deprivation or whose situation may have been exacerbated by the pandemic. CRTs has representation from Sutton primary care networks, Sutton Council, Sutton Health and Care Community Services, charities and voluntary sector organisations. • Consultation on the appropriate model for PCN and community services neighbourhood team has been completed • Developed the Maximising Independence service with community frailty, falls pathway to improve MDT proactive care for patients with frailty and falls risk. Falls prevention classes with transport provision for access is provided. • A Front Door MDT Team to proactively assess patients within the emergency department in acute hospital and avoids admission where appropriate. • South West London Ageing Well Programme investment for 2 hour Community Rapid Response, anticipatory care and Enhanced Health in Care Homes we support the development of a whole systems approach that puts the Sutton Virtual Ward at the heart of a preventative, proactive and reactive model to support prevention of hospital admission and hospital step down pathways • Developed a falls response (falls pick up) service by integrated working between Home First, Night Nursing and GP Acute Home Visiting Service that avoids long lie for patients who had a fall, reducing ambulance call outs and hospital conveyance. • Strategy for delivering end of life care through the palliative care coordination hub, Enhanced Health in Care Homes and the Primary Care Network Directed Enhanced Service is being developed • GeriPall project: early identification of severe frailty that may lead to palliative care. Integrated working between Acute Frailty Unit, continuing health care, Home First, continuing health care and Palliative Care Coordination Hub, that helps to have appropriate conversations with patients' family and carers. Helps with speeding up

fast track referrals and processes, improving patient/family/carer experiences and future plans for crisis situations are carried out by the project team.

What do we plan to do next?

Sutton Community Virtual Ward

- Establish Sutton Community Virtual Ward hospital step down facilitated early hospital discharge model of care to support pressure on emergency services and hospital beds
- Implement the review of urgent care pathways and interface with the Virtual Ward
- Enhance the transfer of care hub function with integrated virtual ward discharge coordination with home first and care home discharges

Cheam and South Sutton (CASS) PCN, Age UK Sutton and Sutton Lodge

- CASS PCN project targeting elderly living in high rises in South Sutton to address social isolation

Maximising Independence Service

- Further develop the pathways to improve the joint working between various services that deals with frailty. Improve by having Pharmacy, Frailty GP and Frailty consultant input

Sutton Health and Care – 2-hour Community Urgent Response

- Enhance the current 2-hour response by continuing to provide the falls response pathway. Integrated pathways with telecare, ambulance services to prevent long lie for patients who had a fall and prevent potential hospital admissions
- Increase the capacity of the existing workforce to provide the flexibility that is needed to deploy staffing resources across the system to support the implementation of an integrated single point of access and 2-hour urgent response
- Implement model to support Intravenous antibiotic therapy for Virtual Ward facilitated early hospital discharge model
- Coordinate community crisis response through one local single point of access by March 2022 ensuring a ‘no wrong-door’ ethos is applied. The single point of access would ensure access to multidisciplinary clinical and non-clinical input and drive referrals from all sectors to the Palliative Care Coordination Hub.
- Red bag coordination for care home residents presented to acute hospital. Carry forward with the e-red bag project support in the acute hospital.

Planned activities for 2022/23

Sutton Community Virtual Ward

- Establish Sutton Community Virtual Ward hospital facilitated discharge step down model of care to support relieve of pressure on emergency services and hospital beds

Maximising Independence Service

- Implement the redesigned falls model
- Further develop the pathways to improve joint working between various services that work with frailty through involvement of pharmacist, Frailty GP and Frailty Consultant.

- Improve the response time for rehabilitation of patients in their own homes. This proactive care in the community would support independence and reduces crisis situations

Cheam and South Sutton (CASS) PCN, Age UK Sutton and Sutton Lodge

- Implement CASS PCN project targeting elderly living in high rises in South Sutton to address social isolation

Sutton Health and Care – 2 hour Community Urgent Response

- Two hour community rapid response is fully operation across Sutton Health and Care Community and At Home Rapid Service and the Sutton PCNs Acute Home Visiting Paramedic Service
- Fully implement the local single point of access for 2 hour community urgent response
- Develop **community crisis response pathway for care homes** to prevent avoidable admissions and reducing the need for conveyancing by **enhance the** capacity of Community Nursing Service to provide urgent 2-hour unplanned response. Investment required to finalise model - 5 *band 6s, 5*band 4s to fully embed the 2 hour response.
- Implement self-referrals for all patients (currently exists for known patients) and diversion of activities from London Ambulance Service and NHS 111 including development of comprehensive user communication and engagement plan
- Fully develop the front door frailty service. Integrated working with the @Home and Frailty consultants

Sutton Health and Care – Enhanced Health in Care Homes

- Commission additional *2 WTE staff to support Enhanced Health in Care Home and targeted prevention and hospital avoidance intervention to learning disability care homes and supported living accommodation
- Implement targeted EHCH support to learning disability residential care homes and supported living accommodation
- Red Bag coordination – continue the red bag coordination for patients that from care home presented to acute hospital. Carry forward with the e-red bag project support in the acute hospital. Requires continuation of funding for Afc band 4 post after March 2022

End of Life Care

- Palliative Care Coordination Hub is fully operational and reducing non elective long stay (NEL) Length of Stay
- Sustain primary care commitment and improve links with acute and borough services
- Increase patient and carer support referral to the Palliative Care Coordination Hub
- Embed Palliative Care Hub into local delivery and secure long-term funding
- Further develop and continue the Geri Pall project. Requires continuation of Frailty GP, Nurse x1 (CHC and Home First shared), Band 4 x1 funding
- Implement integrated social care and primary care approach for advanced care planning
- Scope end of life care training and educational needs of health, social and carers across Sutton

How do we know we are making a difference?

Sutton Community Virtual Ward

- Increase capacity of the Virtual Ward to 100 patients at any one time by March 2022

Sutton Health and Care – 2 hour Community Urgent Response

- > 70% of patients who require a community urgent response are seen within 2 hours of referral
- 60 % of patients that seen for a community urgent response is prevented from admission to the hospital

Sutton Health and Care – Enhanced Health in Care Homes

- Reduction in London Ambulance Conveyance from care homes
- Reduced attendances to Emergency Department

End of Life Care

- Reduction in average non elective long stay (NEL) Length of Stay for people during the last 12 months of their life
- % increase in GP palliative care lists,
- % dying in the preferred place of death
- Reduction in >3 admissions in last 90 days stats
- Seamless care for patient with advanced frailty in anticipation for end of life – reduction in referrals to discharge from hospital time.

What difference will this make to people in Sutton?

- Improve how we combat loneliness and social isolation among older people:
- Improve outcomes for people being discharged from hospital with advances frailty, dementia and/or long term degenerative conditions
- People die in the Preferred Place of Death and improved coordination of care in the last year of life and support to carers
- By providing the most effective access to emergency care and the best quality care, and by reducing pressure on emergency services, our local people can:
  - be better able to prevent crises and unnecessary visits to hospital, avoidable admissions or lengthy stays in hospital.
  - have access to the right treatment in a timely way to stabilise their condition and manage their needs

Age UK Sutton brings to the Sutton system expertise in working with older people and a wealth of skills, knowledge and volunteering resources. A future focus for Sutton is how we combat loneliness and social isolation among older people

Spotlight on Age UK (Sutton)

Age UK Sutton (AUKS) is an independent, local charity with just over 30 staff, 50 workers in their Social Enterprise 'Help@Home', and around 100 volunteers. The charity is a 'brand partner' of national charity Age UK, and as such benefits from membership of a network of similar small independent charities across the UK, whilst being able to maintain full independence, and a focus on local issues in the London Borough of Sutton.

Age UK Sutton delivers a mixture of services, social and community activities, and is increasingly involved in local influencing and strategy. Age UK Sutton is funded through a carefully managed blend of grant funding, local donations and fundraising, commissions, and income generated by our Social Enterprise activity.

Our strategic priorities are:

- Provide services that make a difference
- Work effectively in partnership
- Influence for lasting change

Our Mission is to make Sutton a more Age Friendly Place

Age UK Sutton is the lead partner for the older people's strand of the Sutton Plan, the local plan to develop services and improve life for all residents in Sutton. In 2020, Age UK Sutton and Sutton Council co-signed a commitment to work towards the World Health Organisation's Age Friendly Communities accreditation. The charity works extensively in partnership with a wide range of other local charities, community groups, and statutory bodies including the NHS and the Council. We are proud to be part of many Boards and working groups, providing expert insight, advice, and support for local planning and development, ensuring that the diversity of older people's circumstances, potential, and challenges are considered, and that stereotypes of older people's needs are challenged and dismantled.

Age UK Sutton's main work is in providing services that make a difference to local older people. We take a 'what matters to me' approach, using our rigorously designed and evaluated Person Centred Assessment Tool (P-CAT) to understand the older person's whole life, goals, strengths, and worries. We then work with them, and their family and carers if appropriate, to make a plan, focusing on their priorities and enabling independence and choice. Age UK Sutton is committed to continuous improvement, and we carefully monitor and evaluate our impact, client feedback, and the environment to ensure that we can respond to changes at a local and national level and anticipate emerging challenges effectively.

In the 2020-2021 year, **Age UK Sutton has supported over 4500 local residents** in the London Borough of Sutton – this represents over 10% of all local people in later life (55+) and is over 50% more than the number of people supported in 2019. In the current year (2021-2022), we are seeing continuous and rising levels of need – a combination of increasing need, greater complexity of issues, and other services closing or shrinking, mean that we are needed more than ever.

Services fall into three main categories:

Support with significant life changes – we help people with money issues, housing problems, bereavement, illness, and increasing care and practical support needs. We provide person-centred advice and support so people can make their own informed decisions about what is best for them.

Combating isolation and loneliness – we support hundreds of lonely and isolated people through our Community Connectors programme, that provides one to one calls and visits from trained volunteers, and helps people form new friendships in their community. We also run special events like our 'all requests' dance parties, monthly 'First Tuesday Club' social gathering, and special seasonal events like festive lunches and Valentine day dinners.

Helping people to manage and improve health and wellbeing – we are proud to provide support for people living with dementia, help managing after a stay in hospital, and specialist services for older people managing mental health conditions. We provide a range of activities to support wellbeing too, including exercise classes and walking groups, singing and dance groups, as well as holding a local directory to help older people find all of the other brilliant opportunities available across the Borough.

Age UK Sutton also operates a Social Enterprise, 'Help@Home', which provides personalised, high quality support for older people to enable them to remain independent at home. This is frequently used alongside a package of care to complement and enhance its impact. The service provides support with household tasks, admin, shopping, appointments, and much more. Clients see the same worker at every visit, so the service also serves a vital role in monitoring and prevention, alongside helping people to maintain independence and quality of life on their own terms.

For further information about Age UK Sutton, please contact the CEO, Nicola Upton – nicola.upton@ageuksutton.org.uk

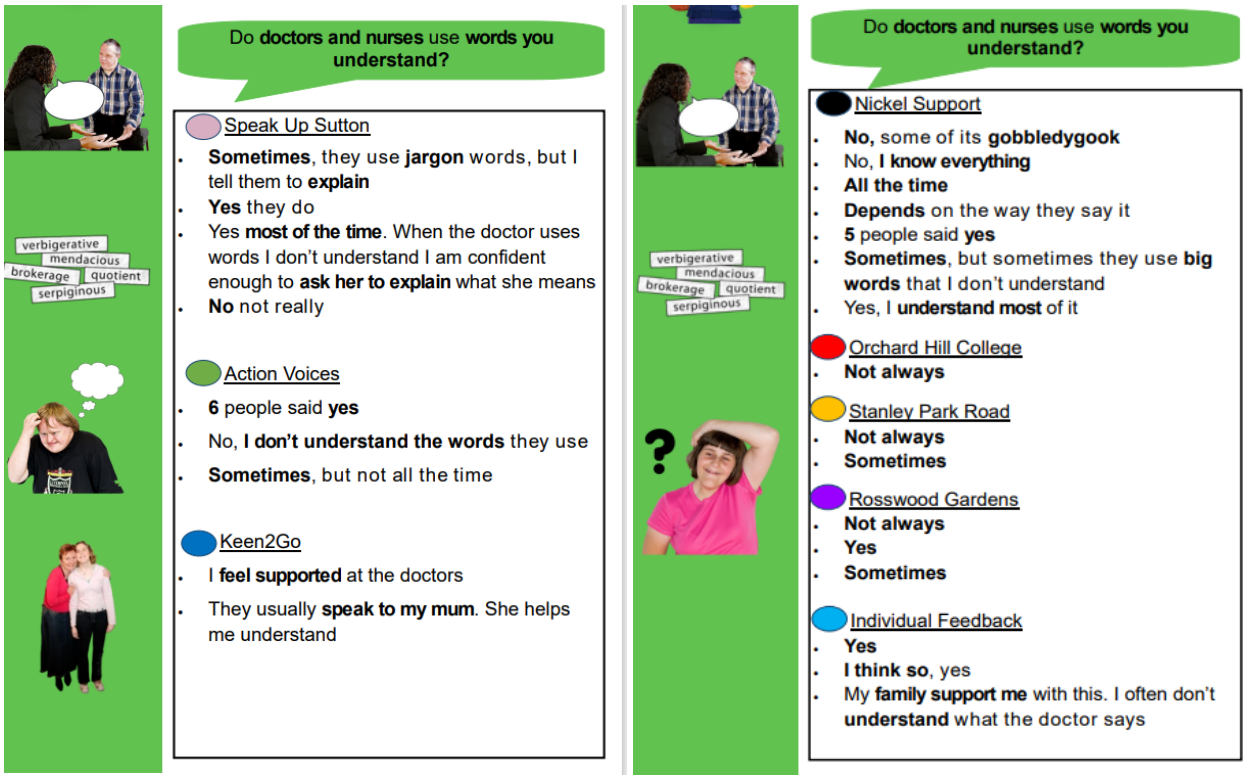
Our website is at ageuk.org.uk/sutton

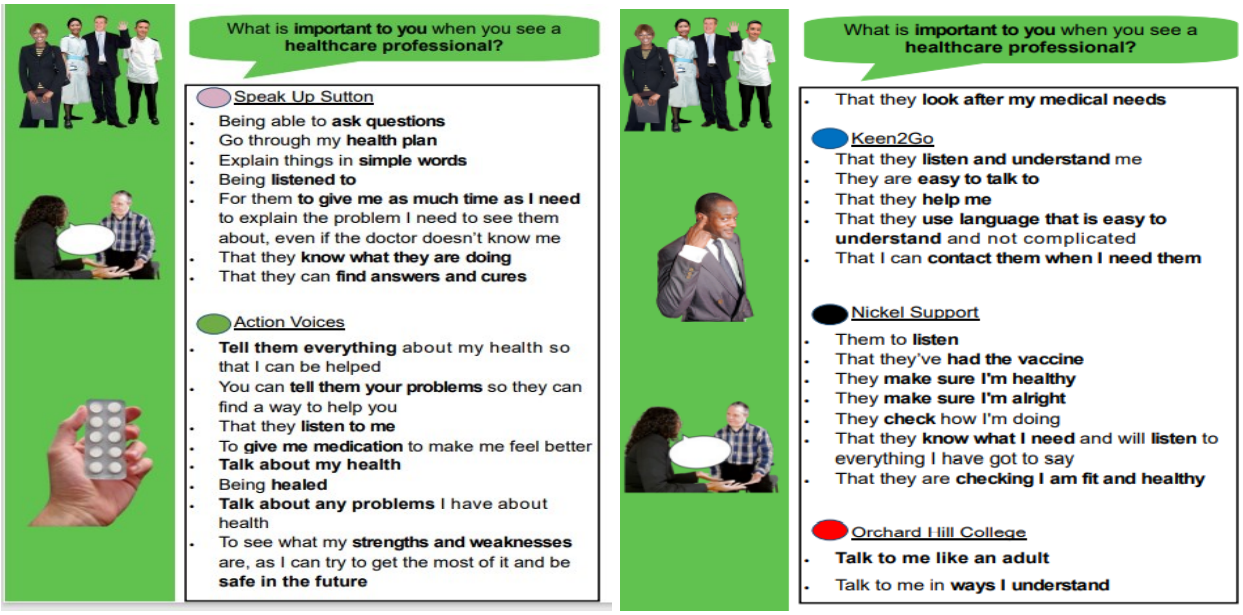
And you can find us on Twitter, Facebook, and Linkedin @AgeUKSutton

What you told us about COVID-19 pandemic

Sample feedback from the Advocacy for All Feedback from Learning Disability Strategy Consultation, the Healthwatch Sutton COVID-19 Experience Surveys, The Stronger Sutton Conversation: Residents' Survey and our health and care partnership COVID-19 Listening Events are outlined below.

Advocacy for All Feedback from Learning Disability Strategy Consultation





Feedback from Healthwatch Surveys on COVID-19 Experience

Being pregnant, it has meant I have had to stop work completely and has changed some of the maternity services available to me. For my husband, it has completely affected his industry and he has had to take a significant pay cut.

My mum died in February and I was unable to visit her grave for several weeks as the cemetery as only allowing funerals. My partner and I do not live in the same household at present. We used to spend each weekend together but I have not seen him now for almost 8 weeks. This has been extremely difficult for me, especially whilst still grieving the loss of my mum.

It's changed our lives completely, self-isolation especially. Our physical and mental health, as well as our social lives have all been impacted. It's made us realise that we should appreciate the small things, and not take things for granted (especially loo roll!))

Depression and lethargy is beginning to set in. Everything has been an upwards battle and because of lockdown I cannot get the outside help that I usually hire in.

I have children and they are not in school and I have to work from home meaning I am not attending to their school work needs. It is a lot of pressure of working parents especially those who are lone parents. My mother has been self-isolating and cannot offer support, my children feel lonely and isolated.

Experience of residents (care homes for both learning disability and older people)

"The lockdown stopped me from doing my normal lifestyle tasks. I was not able to go to the local shops."

"Cannot have visitors. They say I cannot go out. Only stay in the lounge or garden. Limited visiting."

"Obviously like everywhere. No visitors or family except some exceptional circumstances. It has been a very difficult time for us all."

"Not being able to see my family has not helped me at all. I have been extremely emotional at times."

"I couldn't see my friends and family. I couldn't go out with my friends. They are my life."
"I came to * during the pandemic and not being able to see family has been really hard."***

Feedback from The Stronger Sutton Conversation: Residents' Survey

Early findings from online survey respondents (649 residents) relevant to the development of the Sutton Health and Care Plan are set out below. It should be noted that these are indicative findings pending a fuller analysis after engagement ends

Themes	Response
What would you like to see more of on your local high street?	Respondents ranked community projects in empty retail units as the second most important followed by independent shops
Top three priorities for your local area over the next few months?	Improving mental health support and giving people more of a say in shaping their local area were in the top five priorities. Giving people more say was in the top three priorities.
What help or support do you need, if any, due to your experience of Covid-19?	Total of 45% of 629 respondents selected support on health or medical, support with mental wellbeing, anxiety or depression, staying active and support
Support for unemployed residents and those who have seen their household income fall	71% of 646 were very/fairly concerned about support for unemployed and those who have seen their household income fall
Thinking about Sutton's recovery from the pandemic to what extent are you concerned about any of the following, if at all? - Impact of lockdowns on education	77% of 641 were fairly concerned / very concerned
Thinking about Sutton's recovery from the pandemic to what extent are you concerned about any of the following, if at all? - Support for older and vulnerable people	84% of 646 were fairly concerned / very concerned
Thinking about Sutton's recovery from the pandemic to what extent are you concerned about any of the following, if at all? - Support for children and young people (inc. with learning/mental health issues)	77% of 645 were fairly concerned / very concerned
Thinking about Sutton's recovery from the pandemic to what extent are you concerned about any of the following, if at all? - Bereavement and counselling services to support those affected by the pandemic	65% of 644 were fairly concerned / very concerned
Thinking about Sutton's recovery from the pandemic to what extent are you concerned about any of the following, if at all? - Access to medical support, such as routine NHS appointments and face to face contact with GPs	90% of 645 were fairly concerned / very concerned

Feedback from COVID-19 Listening Events

COVID-19 Listening Events was held with the following organisations/groups:

- Sutton Health Champions
- BAME Equality Task Group
- Patient Reference Group
- Afro Caribbean heritage Associations
- Sutton Parent Carer Forum
- Age UK Sutton
- Sutton Safeguarding Adults Board (representatives from Sutton Carers' Centre, Speak up Sutton, Safer Sutton Partnership, Sutton Mental Health Foundation, voluntary groups (Age UK, Sutton Voluntary Services and Nickel projects), ethnic and religious, South Asian Group, Central Mosque and Sutton African and Caribbean Cultural organisation
- Homestart
- Mental Health Forum
- Purely Masjid Mosque
- Playwise
- Carshalton Diabetes Group
- Sutton Health and Care School Nursing Team
- St Helier 2040
- Good Shephard Church
- Holy Trinity Church
- Sutton Local Committee
- Sutton residents Q & A
- Sutton Carer Steering Group
- Sutton School Nursing Team

Below is a sample feedback and comments on the impact of the COVID-19 listening events:

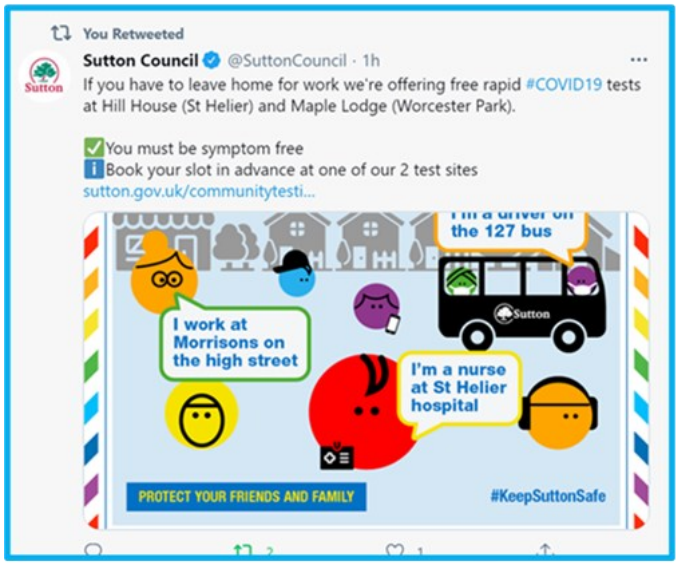
"Thank you so much for an excellent workshop. I'm so glad we arranged it. The feedback was very positive. I suggested the recording, or a summary be shared with faith groups as they have a captive audience at least once a week."
Beverley Dixon, ACHA Chair

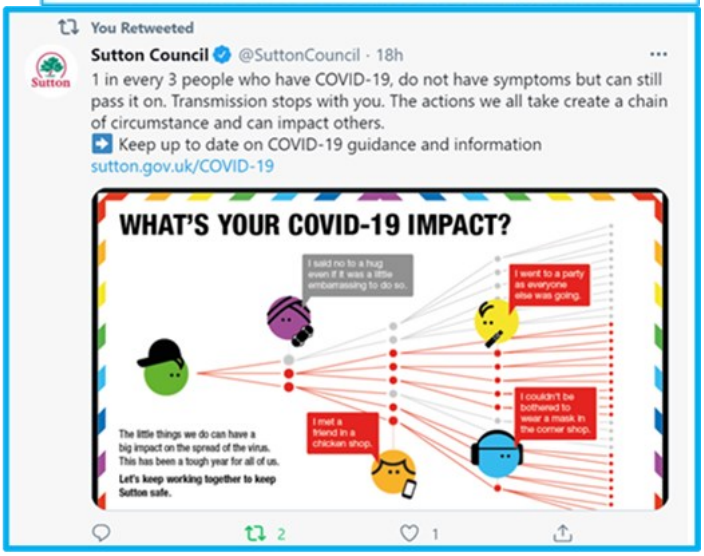
"*Thank you so much for presenting your Covid-19 updates to the local Committee on Thursday. I thought they were excellent. I really appreciate the macro and micro approaches to your work. Thank you for your hard work and dedication to Sutton".*
Cllr Ali Mirhashem

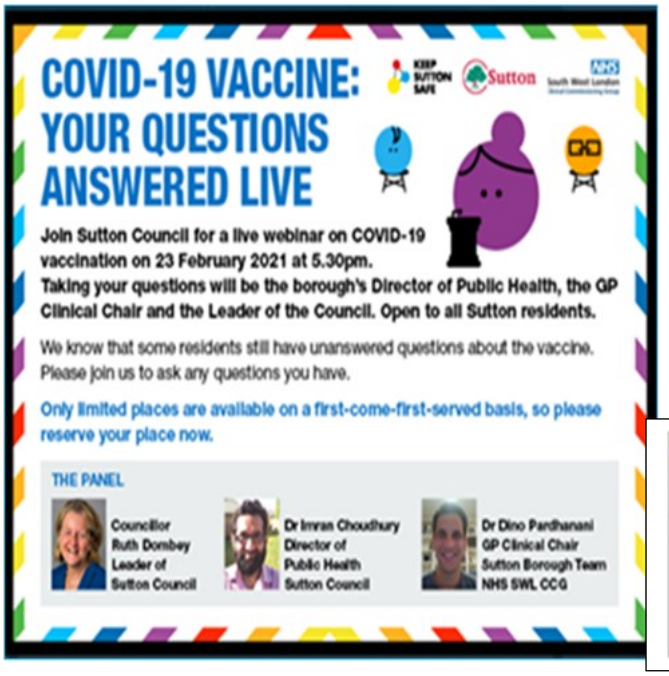
"There is a real sense of strong community cohesion and support, and this model of engagement has really helped foster that way of working. We hope this continues".
Cllr Lilly Bande

"I felt very reassured after listening to the GP and will share the key information with the Somali Group I represent"

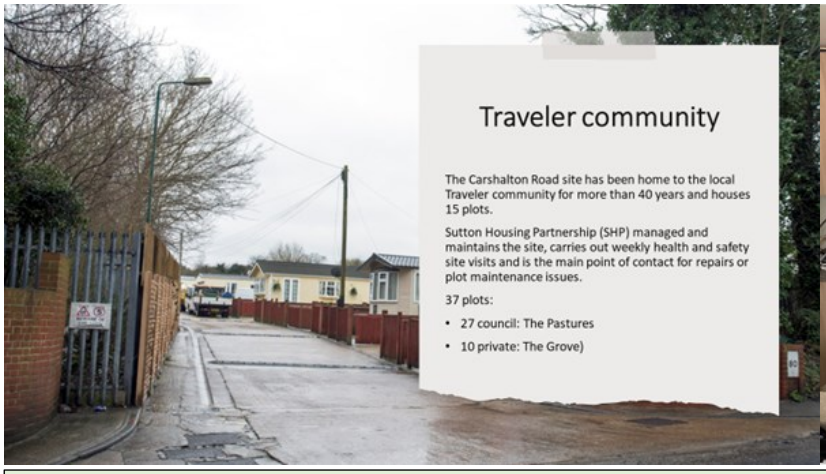
Examples of COVID-19 promotional and media material







Examples of targeted outreach during COVID pandemic



The Partnership
Sutton NHS worked in partnership with Sutton Council (Sutton Housing Partnership), Cognus (Education Traveler Service) and the Public Health team at Sutton Council, to help increase vaccination uptake within the Traveler community in the borough.

What we did

1. 2 visits were arranged with Sutton Housing Partnership Lead and Cognus (introductory phone calls)
   - Introductory visit to build trust at the Pastures Site
   - Second visit to give Covid vaccine (both sites)
2. The joint team liaised with the Traveller community to arrange an on-site information session and offered to vaccinate anyone over the age of 18 on-site who wanted it, without the need for the Traveller to attend a GP surgery.
3. Travellers were also able to ask any questions surrounding the vaccine and receive reassurances from [Dr Ellie Bernard, Partner at The Manor Practice in Wallington]. Advice was also given on the all-around health service available from local health services in Sutton.

Outcomes

- 22 Travellers received the COVID-19 vaccination on 11 March 2021 (The Pastures) and 6 (The Grove).
- Trusted relationships formed: 6 families have shared their personal contact details with Senior Engagement Manager (Sutton) which shows trust has been established.
- 4 families are in the process of changing surgeries from Banstead to Manor Practice

Vaccine Minister, Mr Nadim Zahawi Visited the Twilight Ramadan Clinic on 30th April 2021 and send a thank you letter to all those involved.

Department for Business, Energy & Industrial Strategy

Department of Health & Social Care

Nadhim Zahawi MP
Minister for Business and Industry
Minister for COVID Vaccine Deployment

Department for Business, Energy & Industrial Strategy

Department of Health & Social Care

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Ahad Surooprajally
Dr Kashif Aziz

By email to:
ahad@companionsofthemosque.com
azizkashif@hotmail.com

17th May 2021

Dear Ahad and Kashif,

Thank you for hosting my recent visit to the Sutton Ramadan twilight pop-up clinic on 30th April.

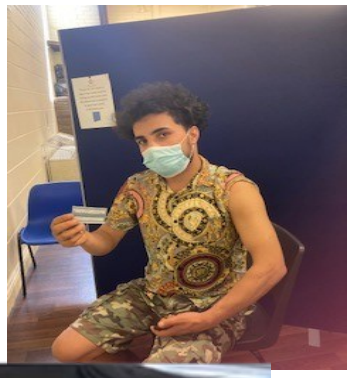
I want to emphasise that you and your team are doing a superb job delivering the vaccination programme locally. It was a pleasure to see your terrific work first-hand and to meet the volunteers on the ground, which I particularly enjoyed. The sense of cohesion within this multi-ethnicity and multi-faith community was evident, as the whole community came together to deliver this project and accommodate Muslims during the Holy month of Ramadan.

As I mentioned on my visit, the Government is working hard to ensure that we are able to support communities like yours to encourage vaccine uptake and to deliver the vaccine programme successfully. I am truly grateful for the role that you and your team are playing in these efforts. We are seeing that the vaccine is working and is having a real impact. It is through the efforts of programmes like yours that we able to protect the NHS, save lives, and return to normal. Keep going!

Yours sincerely,

NADHIM ZAHAWI MP
Minister for Business and Industry
Minister for COVID Vaccine Deployment

Vaxi Taxi Sutton COVID Vaccination and Health Event



Video can be accessed here:

(21) Vaxi Taxi in Sutton - YouTube