South West London
Health & Care
Partnership

Sutton Health and Care Plan

2021 refresh

Start Well | Live Well | Age Well

Sutton

The revised Sutton Health and Care Plan builds on our successes, considers the impact of the COVID-19 pandemic and takes a fresh look at how we can continue to deliver the best care for our population. Reflecting local population data and the views of residents, health and care professionals and partners, we have reviewed the priorities that were agreed in 2019 and our approach to working with local people to deliver our ambition to support our population to start well, live well and age well.

12%

of Sutton school pupils have a special educational need

(lower than the London average)

Around 18,300

carers live in Sutton, and a significant number of those live in the most deprived wards – St Helier, Wandle Valley and Wallington South

Estimated **8.5%**

of young people aged 5-16 years have a mental health condition

Around 33%

of GP registered patients have multiple, long term conditions

Predicted **19%**

increase in people with a learning disability need by 2030. The largest increase will be in people aged 85 years and over

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

There are around

2,300 people

living with dementia in Sutton

59% of people who use social care services, and 72% of adult carers, say they do not get as much social contact as they would like

Between March 2020 to March 2021, the proportion of people claiming benefits rose from

2.4%

to **5.8%**

Our vision

We want to sustain and develop:

- good quality of life
- access to decent jobs and services
- and strong communities

We also want to ensure that these benefits are shared by everyone in our community, tackling the inequalities experienced by some of our residents.

Start well

While most local children have supportive families, access to good education and services, there are still too many children who are not able to benefit from the opportunities and support available to them and the number of children and young people seeking support for mental health issues continues to rise.

We want all children to be able to thrive and achieve their potential.

Live well

Our aim is to focus on reducing health inequalities through better understanding of the health and care needs of the population.

We want to ensure that people with a learning disability; serious mental illness and health conditions such as diabetes and obesity are supported and able to make healthy lifestyle choices.

Age well

Older people with health conditions should be able to retain their dignity, be able to avoid going into hospital when they can be better cared for at home and have access to the right treatment in a timely way.

In the last year of life, better coordination of care and support to carers will enable people to have more choice over where they die.

What we've achieved so far

There are many examples of health and care and voluntary sector partners working closely with communities to join up services and improve outcomes including:

Supporting children and young people's mental wellbeing

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, through developing positive relationships that build confidence and improve children's performance in school.

Mental health support teams are now in place in some schools focusing on building emotional resilience in young people and teachers have been trained in Mental Health First Aid.

Addressing domestic abuse

We developed a multi-agency approach to supporting victims of domestic abuse and addressing behavioural change in perpetrators of domestic abuse. The 'Transform' programme has worked with 2,583 victims and children, and 166 perpetrators of domestic abuse since November 2019. 100% of victim respondents reported feeling safer upon case closure and 97% reported that abuse had reduced or stopped.

Improving the health of people with learning disabilities

We have improved the specialist support provided for adults with learning disabilities and undertaken a joint health and local authority review of how we commission services for people with learning disabilities in Sutton.

Mental health support

We launched the Sutton Crisis Café in August 2021. This is for anyone over 18 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 for a while.

Addressing health inequalities

We identified that Carshalton has the highest diabetic population in Sutton. The Diabetes UK Carshalton Group played a key role in the development of peer support for diabetes model of care for people living in Carshalton. Obesity rates are higher in the most deprived areas and obesity in children is likely to cause ill health in adulthood. The Roundshaw Whole Systems Obesity Pilot aims to improve the long-term health and well-being of the population of the Roundshaw estate in Wallington by addressing nutrition, movement, sleep, stress management and personal environment modification.

A virtual ward in the community

Sutton Community Virtual Ward was established 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 opening in February 2021.The virtual ward has the capacity to support 100 patients at any one time and now includes people with long term conditions such as heart failure, lung disease and frailty, monitoring their health and providing care from a multidisciplinary team.

Our plans

Health inequalities and the impact of the Covid-19 pandemic

The Public Health England report Beyond the data: *understanding the impact of Covid-19 on black, Asian and minority ethnic groups (2020)* highlighted the unequal impact of Covid-19 on these communities. The impact may be explained by factors ranging from social and economic inequalities, racism, discrimination and stigma and occupational risk.

Our data confirms that people who live in geographical areas of deprivation across Sutton are most likely to be significantly impacted by the Covid-19 pandemic. High prevalence of obesity, diabetes and mental health was highlighted by the King's Fund Independent Review of Health Inequalities in Sutton and Merton (2021).

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

St Helier, Wandle Valley and Beddington South have poorer health and wellbeing in comparison to Sutton. 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.

Start well

School readiness

Not enough of our children are ready for school by the time they reach their reception year. This leads to children not reaching desired levels of emotional, social and physical development combined with low levels of basic numeracy and literacy. One measure to support families with young children will be the development of family hubs in Sutton where families can be supported by an integrated team.

Mental health

Levels of stress and anxiety amongst young people have increased and demand for children and young people's mental health services continues to grow. We are working to identify how to use data to identify mental health needs and develop a long-term approach to tackling mental health issues.

Children with special educational needs

We want to maximise chances for 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.

Live well

Learning disability

We are developing a five-year Learning Disability Strategy 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 this will give individuals the best possible outcomes and ensure improved health and wellbeing.

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.

Population health management

We are focusing on people aged 20 years and over with chronic musculoskeletal (osteoarthritis) conditions, high blood pressure, obesity and depression who live in areas of high deprivation in Sutton. We are developing the model of care and outcomes and will test these with the affected communities.

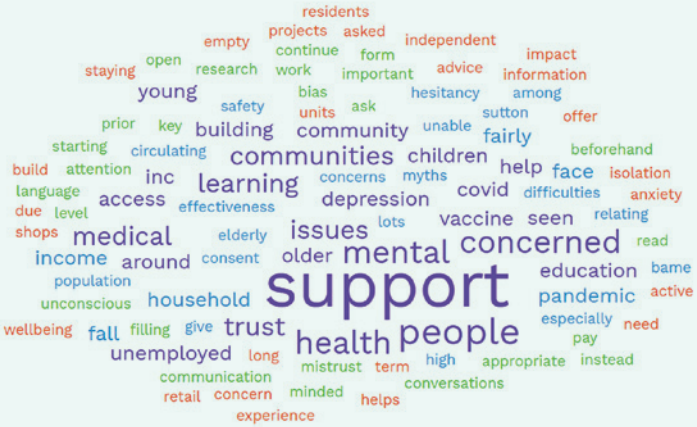
Age well

Frailty programme

Through our frailty programme, we aim to develop a better joined up approach to all the services that support frail people in Sutton. We want to ensure a consistent Sutton-wide approach to improving the care provided to people so that there are smooth transfers between care settings and a focus on maximising people's independence and supporting people at home or to return home as soon as possible.

What people have told us

The main themes:



- People are concerned about the impact of COVID-19 and recovery
- They need support with mental health issues such as depression, isolation and anxiety
- They are concerned about the myths circulating about the effectiveness and safety of the vaccine
- They are interested in seeing empty retail space converted for community projects
- They are concerned about access to medical support, such as routine NHS appointments and face to face contact with GPs
- There was lots of positive feedback and support for the model of engagement developed 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 (initial findings relevant to the health and care plan based on 649 respondents), conversations with leaders of local grass roots organisations and COVID-19 Listening events.

What difference will this make?

Start Well

- More 0-5 year-olds with complex needs identified and offered support
- Children and young people report improved mental and emotional health
- Better experience for children with Special Educational Needs and Disability and their families

Live Well

- People will be able to live as independently as possible at home and to return home quickly and safely after a hospital admission
- People with Type 2 Diabetes will manage their condition and require fewer GP attendances
- 75% of people with a learning disability will have had an annual health check 2023/24 (performance was 69% in March 2021)

Age well

- People will have access to the right treatment at the right time to stabilise their condition and manage their needs
- People will choose where they want to die with better coordination of care and support for carers in the last year of life

This is a summary of the Sutton Health and Care Plan. You can read the full document at **Commissioning health services in Sutton - South West London CCG**