Wandsworth Health and Care Plan 2022-24

Draft 0.5

May 2022

CONTENTS

1. Introduction

The Wandsworth Health and Care Plan outlines the vision, priorities and actions to meet the health and care needs of local people and deliver improvements in their health and wellbeing through the life stages of; start well, live well and age well. The plans is focused on the areas where, over the next two years (2022-24) partners from across health, social care and the voluntary and community can have the greatest impact by working collectively.

This plan builds on the Health and Care Plan 2019-2021 that identified and made great progress on shared goals to improve health and wellbeing. While our work was disrupted by the pandemic, the whole community came together to meet the challenge, this plan reflects refreshed priorities and learning from implementing the previous health and care plan.

Health, social care, voluntary, community organisations and residents across Wandsworth have been involved in shaping and developing this plan. As a partnership, we have a shared commitment to work together, focusing where we can add value and have the greatest impact and we recognise that we all share a responsibility to ensure our social care, community, wellbeing and hospital services are as joined up as possible.

The Wandsworth Health and Care Plan is one element of work being undertaken by health and social care partners in Wandsworth and across South West London to improve health and wellbeing. The priorities within the Wandsworth Health & Care Plan are focused on the areas where, over the next two years, we can have the greatest impact by working collectively to prevent ill health, keep people well and support them to stay independent.

The strength of our response to the coronavirus pandemic in Wandsworth was rooted in how health and social care partners collaborated across organisational boundaries, to work with our communities to keep the most vulnerable protected, shielded and supported. Through establishing Integrated Care Systems as a statutory body in July 2022 it is hoped to strengthen collaboration in the NHS and wider partners. A key part of the new Integrated Care System approach is to strengthen ‘place’ based partnership and collaboration between health, social care and voluntary sector partners.

2. The vision for health and care in Wandsworth

After talking with our community, we have revised the health and care vision to:

Wandsworth is a place where people are supported to live healthy, fulfilling lives in thriving communities. We will work together to make a difference to the people of Wandsworth to ensure everyone has the chance to:

- Have the same life chances, regardless of where they are born or live.

- Live healthy, independent, fulfilling lives.

- Be part of dynamic, thriving and supportive communities.

- Have equal access to health and social care services

3. Health and Care in Wandsworth – the context

a. Our community

As a vibrant and well-connected borough with many community assets, attractions and facilities, Wandsworth is recognised as a great place to live and work. Publicly accessible parks make up almost a quarter of the total area of Wandsworth and this green space promotes active living and provides important physical, psychological and social health benefits for individuals and the community

Wandsworth is home to an estimated 328,828 residents, the second largest population in Inner London. By 2029 this will increase to more than 373,000, reflecting Wandsworth as having one of the fastest rates of population growth in London. Wandsworth has one of the youngest populations in the country, with a median age around 33.7 years (London=35.1) and has one of the highest proportions of the local population aged 20-44 years, in London. The largest increase in numbers will be among those aged 20-39 years, driven by internal migration from other parts of UK moving into the borough, but the largest percentage increase will be in age groups 60 years and older with the population of those aged 85+ years growing by 42% by 2029.

Many people who live in the borough are affluent, well educated, healthy and in work. Most of the local population report leading happy and worthwhile lives, scoring better than the London average, but there is a subset of around one in five who reported low happiness, satisfaction, and high anxiety scores.

Wandsworth borough has an active and well-developed voluntary sector with over 900 organisations offering a diverse range of services. The sector is supported by the council's Voluntary Sector Partnership team, part of the Community and Partnership group, which works across both Wandsworth and Richmond.

There are 88 places of worship in Wandsworth. Beyond their religious role, many of these places act as gathering places for community events. This may be an underestimate as other places of informal gathering may not be listed.

Potential statistics for an infographic:

- Healthy life expectancy (the number of years of life without serious illness) is 66.9 years among men and women in Wandsworth. This age has been steadily increasing in men since 2001/03, while for females the healthy life expectancy has fluctuated.

- Overall in Wandsworth 38% of residents live within the 50% most deprived Lower Super Output Areas (LSOAs) nationally, this has improved from 47% in 2015.

b. Our challenges locally – what our Joint Strategic Needs Assessment tells us

The coronavirus pandemic highlighted the wider inequalities in our society and how they leave members of our community vulnerable to poorer health and wellbeing outcomes. A greater focus on addressing the underlying conditions to improve health and wellbeing and to tackling known health inequalities is paramount.

Demand for our health and care services is rising due to several factors, including both our growing and ageing population. The success of promoting longer life creates pressures on health and care services as more people live for longer with one or more long term conditions. We are looking to meet this demand through a life course approach focusing on prevention and the wider determinants of health, a clear set of system priorities, and a system commitment towards developing integrated services.

The main challenges we face in Wandsworth are:

- Reducing childhood obesity
- Improving the mental health and wellbeing of children and young people by making it easier for young people to access support, and reducing waiting times.
- Supporting more people living with long term conditions in community settings, enabling them to be supported closer to home.
- Improving the support we provide to the frailest older people in care homes at the end of their lives.
- Improving access to mental health and wellbeing
- Addressing and reducing health inequalities

Tackling health inequalities – The Core20 Plus 5 approach

Health inequalities are experienced between different groups of people and are often analysed across four main categories: socio-economic factors (for example, income); geography (for example, region); specific characteristics (for example, ethnicity or sexuality) and socially excluded groups (people who are asylum seekers or experiencing homeless). The effects of inequality are multiplied for those who have more than one type of disadvantage.

The approach defines a target population cohort - the 'Core20PLUS' - and identifies '5' focus clinical areas requiring accelerated improvement. The approach is made up of three key parts.

Five national clinical areas have been identified that align with national areas of focus. These include;

- Maternity: ensuring continuity of care for 75% of women from BAME communities and from the most deprived groups
- Severe Mental Illness (SMI): ensuring annual health checks for 60% of those living with SMI (bringing SMI in line with the success seen in Learning Disabilities)
- Chronic Respiratory Disease: a clear focus on Chronic Obstructive Pulmonary Disease (COPD) driving up uptake of Covid, Flu and Pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations
- Early Cancer Diagnosis: 75% of cases diagnosed at stage 1 or 2 by 2028
- Hypertension Case-Finding

Potential Wandsworth Core20 infographics include:
-18% of Wandsworth residents are in Core20 population (76,000 people)
- They are predominantly residing in Latchmere and Queenstown wards
- 67% more likely to be diagnosed with a mental health condition

Start well:

Childhood obesity is defined as abnormal or excessive fat accumulation that presents a risk to health and is one of the most serious public health challenges of the 21st century. However, obesity is a complex issue and there is no singular solution. The UK is now ranked among the worst in Western Europe for childhood obesity rates and is one of the biggest health problems the country faces. Nationally, two thirds of adults, a third of 11–15 year olds, and a quarter of 2–10 year olds are overweight or obese.

By the time a child reaches Year 6 the percentage of obese children has increased three-fold to 19% in 2019/20. Wandsworth encouragingly ranks the 5th lowest of all London boroughs for prevalence of obesity at Year 6. These rates are lower than the London rate of 23%, and the England rate of 20%. Wandsworth's obesity levels in Year 6 have remained stable in the last three years indicating further need to increase both physical activity and instil healthy eating habits in primary school (ic groups. Children with learning disabilities are also more likely to be overweight or obese.

Childhood obesity prevalence changes with age and ethnic group. In Wandsworth and nationally, the prevalence of obesity is the highest in Black ethnic groups and the lowest in White ethnic groups; the prevalence in Asian ethnic groups was somewhere in the middle. Interestingly, the pace of increase in obesity prevalence between reception and Year 6 varies even more substantially. For Black ethnic groups, the prevalence in Year 6 is 181% higher than in reception, in comparison with a 261% increase in white ethnic group and 316% increase in Asian ethnic groups

In 2020, 3.0% of Wandsworth's primary school children were identified as having social, emotional and mental health needs, the 4th highest proportion in London (of 32 Local Authorities), a significantly higher value than both the England and London averages. These figures are mirrored by the significant take up of new emotional and mental health services in Primary Schools and Primary Pupil Referral Units, particularly new services to support Social, Emotional and Communication needs, including arts psychotherapies and other psychodynamic therapies, which benefit children and young people for whom talking therapies are not appropriate.

Wandsworth's latest (2020) proportion of secondary school pupils with substantial emotional, social and mental health needs was 4.2 per 100, the 2nd highest in London, 57.6% higher than the England average, and 60.0% higher than the London average. This includes increased levels of complexity and cases where there are higher levels of emotional dysregulation and higher levels of risk from self-harm.

Special Educational Needs and Disabilities (SEND) are also factors that contribute towards higher occurrence of mental health difficulties. There has been a significant increase in the number of children with a diagnosis for Autism (ASD) and Learning Disabilities (LD) in South West London over the last 10 years. This increase has resulted in a scaling up of education, social care and health provision for these children, young people and families. As an example, in Wandsworth in 2020 there were 2418 Education Health and Care Plans (EHCPs) and 6307 pupils with SEND. There has been a major expansion of Wandsworth Special Needs schools to cope with the increasing number of young people with SEND and the creation of more nurture provision within mainstream schools, to support inclusive education. South West London has a higher proportion of EHCPs than the regional and national average, and is a net importer of students with SEND.

In line with the increase in the number of children and young people with SEND there has been an increase in children and young people with autism and/or Learning Disabilities who have emerging 'behaviours that challenge', which can escalate into emotional and mental health needs.

Children with a learning disability and/or autism who exhibit severe challenging behaviours often have nuanced sensory, social & communication needs, emotional dysregulation and patterns of obsessive and ritualised behaviour which their family, school and professional network have struggled to understand and effectively respond to. For children with high functioning autism, often diagnosis happens later in life (between 12 and 16 years old) and their

emotional needs and mental health may have deteriorated ahead of the interventions being put in place. In Wandsworth these increased areas of needs are reflected in growing number of children on the borough's Dynamic Support Register (DSR) who require specialist support and intervention from multi-disciplinary teams.

Live Well:

Good mental health is the foundation for living well and there is a clear link between an individuals mental and physical wellbeing. We know the impact of a person's mental and physical health, their social and environmental surroundings (including employment, housing and factors such as loneliness and isolation) influence the uptake of unhealthy behaviours.

These in turn go on to account for a high proportion of disease and long term health issues such as diabetes.

Potential sources for infographics Diabetes and Cardiovascular:

In 2016–18 the highest number of preventable deaths in Wandsworth were due to cancer, cardiovascular diseases, liver disease and respiratory conditions. All these conditions are affected by health behaviours, such as smoking. For all disease categories, preventable mortality in males almost doubles the rate of mortality in females; this inequality is especially visible in preventable cardiovascular mortality where men's rate almost triples women's rate 44.8/100,000 population vs. 17.4/100,000 population. For all cardiovascular and cancer preventable mortality indicators, Wandsworth's rates are higher than England's–except of female preventable mortality from cancer.

Wandsworth's latest rate of preventable cardiovascular mortality was 30.2 per 100,000 population, 13 th highest in London, which was 7.3% higher than the England average and 9.5% higher than the London average. The latest Borough figure was also 54.1% lower from year 2001–03, in comparison with a 53.8% decrease in England's rate in the equivalent time period. The reduction in Wandsworth's rate have stalled in 2009–11. Since then, the borough's figures oscillated between 30-40/100,000 population.

As a health and care system we are moving beyond a focus on individual behaviour towards a wide range of social and environmental interventions to improve the health of the population and reduce preventable diseases. We are also taking a more proactive approach to certain health conditions, intervening earlier, preventing the serious consequences of these conditions and delivering more efficient care.

Having one or more long-term condition generally reduces quality of life and increases the chances of requiring support from health or social care services. It is recognised that if people with long-term conditions are managed effectively in the community, they should remain relatively stable and enjoy a quality of life free from frequent crises or hospital visits. Local health and care partners are working together to work in more integrated ways to support people with long-term conditions to manage their own conditions and improve the care they receive when they come into contact with health and care services.

There are persistent and significant ethnic inequalities in most aspects of mental healthcare in the UK. Broadly, these can be understood as differences in access, experience and outcomes of mental healthcare, and particularly disproportionate representation and poorer outcomes for people from Black and minority ethnic communities in specialist mental health settings.

Unpicking the causes of ethnic inequalities in health is difficult. Available evidence suggests a complex interplay of deprivation, environmental, physiological, behavioural and cultural factors. Multiple peer reviewed publications and reports over the last 40 years have identified mechanisms and processes to improve mental health care for Black and minority ethnic communities. However, no significant and sustained improvement in access, experience or outcomes has been achieved.

Age Well:

Maintaining health into older age will increase people's chances of remaining independent and in control of their lives. Healthy lifestyles continue to be important, as does staying socially connected and being able to manage long-term conditions. Many older people also find themselves in a caring role. Health and social care provision needs to adapt as the population over the age of 65 continues to increase

Whilst people are living longer, many older people are also living with a reduced quality of life due to ill health or disability, or experience loneliness and isolation. Wellbeing is influenced by our environment, communities and access to healthy choices. This plan will drive forward preventative approaches at all levels; engaging communities, utilising local assets (e.g. parks and open spaces) and targeting approaches to reach those most at risk.

Potential infographics

- 39% of people aged 65 and over live alone in Wandsworth (>10,000 residents). This figure is predicted to increase

- The Survey of Londoners 2018/19 revealed that 30% of the participants from Merton and Wandsworth stated that they often felt lonely, and 22% of participants felt socially isolated, stating that they did not have someone they felt they can rely on in an emergency.

- Wandsworth latest rate of emergency admission due to falls in people aged 65+ was 2,467 admissions per 100,000, the 6th highest rate in London, 11% higher than the England average and 11.4% higher than the London average.

As people get older, they are more likely to fall over. Falls can become recurrent and result in injuries including head injuries and hip fractures. Falls and fall-related injuries are a common and serious problem for older people. People aged 65 and older have the highest risk of falling, with 30% of people older than 65, and 50% of people older than 80 falling at least once a year.12 Amongst older people living in the community, 5% of those who fall in a given year will end up with fractures and hospitalisation. One in two women and one in five men in the UK will experience a fracture after the age of 50.

4. Our other work

The Wandsworth Health and Care Plan is one element of work in Wandsworth and across South West London (SWL) to improve health and wellbeing. The focus of this plan is on the areas where, through working together, we can make an impact on the health and wellbeing of our residents. This plan aligns and compliments existing plans. Other plans include:

- The Prevention Framework 2021-25, embedding prevention as a system tool. Wandsworth Borough Council

- St Georges Strategy 2019-2024

- Health and Wellbeing Board Strategy being refreshed in 2022

- Adult Social Care Digital Strategy 2021-2024

- Carers Strategy 2020-2025

- Safeguarding Adults Strategic Plan 2021-2023

- Sexual Health Strategy 2019-2023

- Suicide and self-harm prevention strategy 2019-2022

- Corporate Plan 2018-2022 (London Borough of Wandsworth)

- Climate Change Strategy 2019-2024

5. What local people have told us

a. Reviewing the 2019-2021 Health and Care Plan

The Wandsworth Health and Care Plan 2019-21 identified 8 key priorities to work collaboratively as a system to bring about positive change and improve the health and wellbeing of Wandsworth residents. Key priorities included:

- Children and Young Peoples mental health
- Risky behaviours
- Integrating physical and mental health approaches
- Chronic disease management – Diabetes
- Health and Social care integration
- Dementia
- Isolation
- Reducing childhood obesity

Good progress was made against the agreed priorities however half way through delivery Wandsworth health and social care partners had to regroup and work together to respond to the coronavirus pandemic.

Figure 1. Summary of delivery of Wandsworth health and care plan 2019-2021

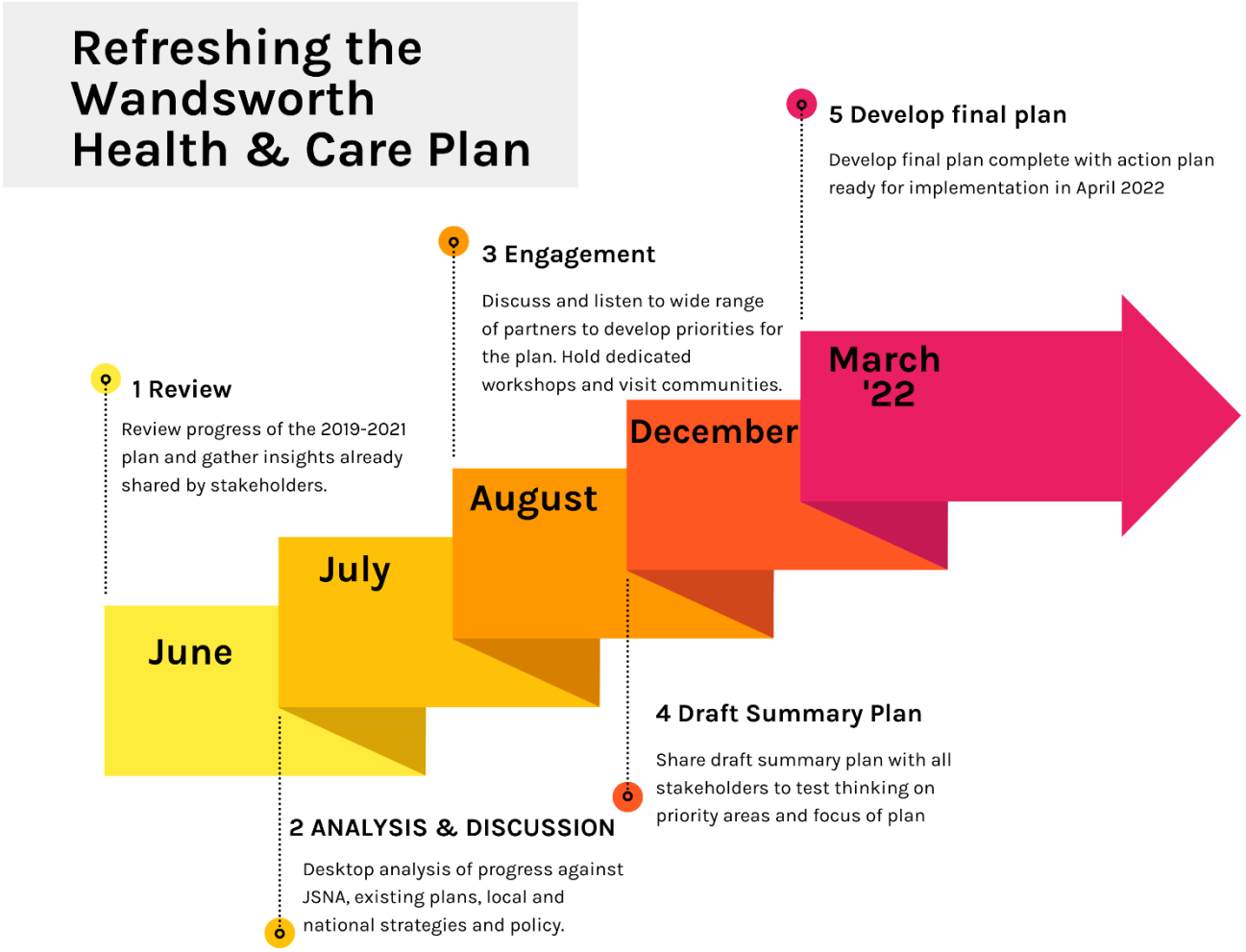
	Priority	What was planned	What has been delivered
Start Well	Childhood Obesity	• To continue to implement the Daily Mile across all primary schools in the borough • Work with leisure and environment partners to encourage more use of open spaces, playgrounds and sporting activities	• Progress was halted by the onset of the pandemic, however many initiatives have been restored and continue to make progress. • A collective focus on ensuring all children received their childhood immunisations was a key priority during 2020-21.
	Children's and Young People's Mental Health	• Improving access and effective support • Whole school emotional resilience programme in primary schools and social and emotional learning programmes for secondary schools.	
	Risky behaviours	• Identifying Young People involved or likely to be involved in risky behaviour • Whole family support for those that are at risk	
Live Well	Integrating physical and mental health approaches	- Increasing access to IAPT services to support people who have anxiety and depression and deliver IAPT long term conditions pathway. - Delivery physical health checks for people with serious mental illness.	- Prioritise existing prevention and LTC management particularly for members of the population who have diabetes, hypertension and a high BMI/obesity - Excellent support and joint working with the CCG to reach underserved communities, reassure around COVID and testing and offer clear and culturally competent messages.
	Chronic disease management – Diabetes	- Introduce a new primary care Local incentive scheme for diabetes to help offer consistent care across the borough - Roll out of national diabetes prevention programme, book and learn and education offer.	
Age Well	Health and social care integration	- Continue to build on integration within intermediate care, with particular focus on rapid response and to facilitate early discharge pathways. - Deliver more integrated care for frail elderly residents in care homes.	• Expanded the digital support to care homes • Developed and delivered a whole system offer to homes in borough • Fully bringing together teams that support the most vulnerable people during the pandemic • Maintaining integrated 7-day week rapid response discharge flow from hospital into most appropriate setting of care • Coordinated system response to planning and delivering timely flu vaccination programme for Wandsworth • Mapped out current support and pathways for dementia care in Wandsworth, produced dementia leaflet.
	Dementia	- improve Care Navigation and planning, integrating dementia care into other care planning streams	
	Isolation	- Work with our partners to support and develop initiatives to combat isolation and its impact on both physical and mental health - Develop and expand social prescribing offer.	

You said	We did
Undertake work to prevent and tackle obesity	- We have been working with partners across the council to incorporate healthy eating and nutritional guidelines into newly commissioned council contracts, for example for older people's day centres and leisure centres. - We have been exploring the feasibility of implementing a policy to restrict the advertising of High Fat Salt Sugar (HFSS) foods across the borough. - We have supported work around promoting healthy eating for those who are at greater risk of developing diet related disease, including adults with learning disabilities and BAME groups.
Improving access to mental health services for children and young people	- Mental health support teams are now in place in some schools, focusing on building emotional resilience in young people. Teachers have been trained in mental health first aid and teams of clinicians are based in children's social care. All CAMHS services are clearly advertised on a simple young person friendly map, which has gone to all schools, GP practices, youth organisation and Council Teams. A range of evidence based preventative programmes are run in schools as part of the whole school approach, including several emotional literacy programmes, such as PATHS, which have helped reduce anxiety and exclusions.

	Wandsworth has a diverse team of CAMHS Young Commissioners that visit services and assess them against standards that young people have identified as important. Dramatherapy provision is available in all Primary Schools. This is a specialist type of support that helps children with autism and other social, emotional, communication difficulties. Proven impacts include improved empathy, social skills, communication skills and reduced problem behaviour. Wandsworth Autism Advisory Service now have a targeted clinical team who provide multi-disciplinary support and guidance to families of children with autism and emerging challenging behaviours. We are also jointly funding a new Behaviour Analyst within this team and assistant psychologist. The outstanding CAMHS LD Service now also has a Specialist Behaviour Analyst to support children and families with severe challenging behaviour, where there is a serious risk of hospital admission and family breakdown. Alongside this Wandsworth now also has a Specialist Key Worker to support children and families in MH crisis. The CAMHS Transition Worker supports improved transition of children with more complex needs to adult Mental Health services, sharing examples of successes and good practice with other professionals to help create system wide improvements. An integrated front-door Single Point of Access makes referral into CAMHS swift, with triage in 24 hours and assessment within 14 days (usually less). There are a range of treatments at Tier 2 including Family Consultancy, Catch22 Counselling, Kooths online Counselling and The Well Centre holistic support and therapy.
Social isolation	Reducing social isolation and loneliness is a priority for Wandsworth. Projects we implement to reduce social Isolation Include: HomeStart Wandsworth, community libraries, Brighter Fair and social prescribing projects. Public Health are working with Council Front Door and CCG on the Wandsworth Social Prescribing scheme which will introduce Social Prescribing Link workers in primary care and adult social care who will support people to address loneliness and social isolation
Improve support to help people identify and proactively manage diabetes	More diabetes champions have been recruited to work with us, helping residents understand the condition. By sharing their experience, our champions help others live longer and more confident lives. What we have learnt has informed our joint diabetes action plan.

b. Engagement and development of 2022-24 plan

It has been essential to develop this plan with local people and the commitment of all partners. Between August 2021 and December 2021 we spoke to around 120 people to hear reflections on the previous plan and their thoughts on how we could work together to improve health and wellbeing in Wandsworth.



Throughout August a series of workshops were held to encourage feedback and reflections on the previous plan, gather experience and expertise from people living and working in Wandsworth to help shape the emerging priorities for the plan going forward. The workshops were:

- open and accessible to all. The workshop is repeated three time during August and has an online feedback option to maximise attendance.
- Same format for different groups – e.g. professionals and service users, carers and community partners.
- Discussed how to develop an ongoing relationship, stretching beyond design into potential delivery approaches and approaches to measure success.

Further spin off discussions and sessions have occurred within existing meetings and forums. These include; Healthwatch Wandsworth, Community group 'Thinking Partners' and a session at the Primary Care Programme Board.
Overall, people were supportive of a focus on health inequalities, mental health and wellbeing as well as greater involvement of the voluntary sector in providing solutions to health and social care challenges, with the right resources.

You said that it was important to address health inequalities and retain a strong focus on improving mental health for children and young people. We also heard that you wanted to build on the partnership with the community that we saw through the pandemic- a key enabler to improving people's health and wellbeing.

What people told us

	what's important/what should be priority for collective action
Start Well	- Focus on inequalities - Focus on Children's Mental Health Eating disorders - Easy and quick access to mental health services was highlighted as important by many including services in schools, GPs practices and community locations, not just at Springfield Hospital site) - Better support for children with social, emotional and communication difficulties, learning disabilities and autism - Digital access to Apps/platforms - We recognise the wider determinants of health; how issues such as poverty and specifically food poverty are linked to wellbeing, in some cases compounding disadvantage and negative outcomes. - Tackling childhood obesity recognising the wider poverty
Live Well	- Focus on reducing Obesity - Wellbeing and mental health - Cardiovascular diseases focus is important - Wider determinants housing/social isolation should be considered in service design - Joined up working with non-health partners is crucial - The barriers to accessing diabetes self-management services should be explored. - Working together with communities to deliver health and care. There have been some excellent examples of this during the pandemic, we want to do more of it. - There should be easy access to people with expertise to help, advise and provide information, including prevention and self-management to keep well.
Age Well	- Focus on carers - Address loneliness and social isolation - Continue to support Care and nursing homes - Frailty - Preventing Falls - Develop and encourage a culture around self-care - Address inequalities including access to digital - There should be more support in place for people with dementia, including lifestyle services and cognitive rehabilitation.

6. Our plan

a. Cross cutting themes

The Wandsworth Health and Care Plan is focused on the areas where we can have the greatest impact by working collectively to improve health and wellbeing. Within each life course of Start Well, Live Well and Age Well, three overarching themes have been identified:

- **Integration**

Recognising that health and wellbeing is about the whole person (social, physical and mental) and that people are part of whole communities and families. We want to work together to improve support that unites physical, mental and social care and empower people to lead happy fulfilling lives. Integrated working across health and care and the community provides the opportunity to deliver the best possible results for the people of Wandsworth.

- **Health Inequalities**

Collectively focus on reducing barriers to access, improving experience and outcomes, through greater co-production, meaning that services are designed and delivered with the community and residents as equal partners.

- **Prevention**

Taking a proactive approach maximises the opportunity we have to jointly improve the health and wellbeing of Wandsworth residents.

The Health and Care Plan recognises that prevention is crucial in reducing health inequalities and staying healthy. The newly developed Prevention Framework will support collaborative prevention work at the individual, community and environment level. The Prevention Framework provides a tool for partners delivering the plan across the life course through sustainable and population based approaches at place.

We are also committed to continuing to protect people in Wandsworth against Covid both by providing care, and through ongoing development of our vaccination offer.

Start Well

What we will do	Description of initiative	What will be the impact?	How we will measure success
Reduce childhood Obesity	- Establish information sharing agreement to improve cross agency working and develop 'Think Family Approach' - Move more; To continue to implement the Daily Mile across all primary schools in the borough and to work towards a sustainable model of delivery for the long term; Work with leisure and environment partners to encourage more use of open spaces, playgrounds and sporting activities - Develop an understanding of the characteristics, demographics, cultural pathological of children and young people at risk of obesity - Deliver Family Weight Management programme - Work with leisure and environment partners to encourage more use of open spaces, playgrounds and sporting activities	- Improved wellbeing and independence - Increase in physical activity for children and families	- Reduction in BMI - Increase in hours of physical activity - Changes in family diet
Improving mental health and wellbeing for children and young people	- Deliver South London and Maudesley's (SLAM) Empowering People Empowering Communities (EPEC) to embed a whole community approach to resilient parenting. - Achieve greater coverage of PATHS – (whole school approach to well-being and Mental Health) - Continue to support Trailblazers project in schools	- Improvements in self-esteem, self control, emotional intelligence, and conflict resolution Greater numbers of CYP receiving early intervention -Improved numbers of CYP recovering from mental health disorders - Reduced stigma and discrimination	- Increases in service utilization - Feedback from children and young people
Addressing inequalities	We will establish an Expert panel to oversee collection of information, experiences and outcomes to understand the disparities in mental health services faced by children and young people. We will co-produce with children and young people service transformations or new models to address the findings.	- Cultural capable workforce - Improvements in access, experience and outcomes - Reduction in health inequalities	- Monitoring uptake in service ustilisation and improved outcomes - Feedback from children and young people
Risky behaviours	- Identifying Young People involved or likely to be involved in risky behaviour - Whole family support for those that are at risk - Development of Multi-Agency Team, within Social Care to work with vulnerable adolescents - Intelligence led disruption and engagement team to identify young people in the community.		- Reduced exclusions – particularly in primary phase

Live Well

What we will do	Description of initiative	What will be the impact?	How we will measure success
Addressing inequalities in mental health	- Develop effective and sustainable partnerships between residents, the voluntary and community sector, the NHS and local authorities to improve health and wellbeing, reduce health inequalities and empower our communities. - We will implement new community based models such as community led health clinics and the Health and Wellbeing Hub as part of the Ethnicity Mental Health Improvement Project (EMHIP).	- Improved access to preventative and early intervention initiatives - Developing partnerships and enabling and empowering communities to tackle health inequalities and long term conditions using a prevention approach and a prevention framework - Culturally capable services, reflective and delivered in partnership with the local community	- Questionnaires/surveys will measure the experience of those using the hub and enhanced therapeutic benefits and wellbeing from community care can be measured via community experience surveys. - Increased numbers of people
Support people to identify and manage their long-term condition	- We will work together to develop and expand community health checks and health clinics, enabling people at risk of diabetes or cardiovascular disease to be identified in a safe space in their community, empowering them to take control of their own health. -Build the capacity and capability within the community to support self-management promoting health and independence	- Early identification, improvement in treatment of and prevention of the complications of diabetes and cardiovascular disease - Improved access as patients can access support closer to home, in the right place and at the right time.	- Improved patient experience and outcomes - Year in year increase in attendance at structured education courses and improvement in patient reported confidence to self-manage - Increased numbers of people identified with atrial fibrillation, BP and Lipid and diabetes
Support people to stay healthy	- Promote health checks and national screening programmes, particularly amongst those at greatest risk of ill health. - Promote health improvement initiatives for weight management, stop smoking services, physical activity opportunities and reduce alcohol consumption.	- More people will be supported to manage their health and wellbeing. This will reduce the reliance on health and care services. - More people will receive timely advice and treatment as required, with improved outcomes. - More local people will join or be referred to health improvement initiatives which are available across the borough.	- Increased uptake in outdoor and physical activity -The uptake of health checks and screening will increase

Age Well

What we will do	Description of initiative	What will be the impact?	How we will measure success
Integrating services	- Review Discharge to Assess arrangements in line with Home First principles - Review current Reablement arrangements and implement - Restructure social care teams based on health footprints to support joint working - Frailty – proactively support, share and identify and work together to support and develop an offer - Work with Carers Centre to provide carer passports and a more flexible approach for carer breaks and improve navigation of health and care services for unpaid carers	- Improved access into intermediate care /reablement services, and better coordination of services - Increased resource and activity provided closer to home, reduction of unnecessary admissions in hospital and shorter length of stay - More people able to live independently and for as long as possible, including people with dementia and other mental health conditions - More people providing unpaid care can balance their caring role with a life outside caring	- Increase in residents who return to normal place of residence after hospital discharge (BCF) - People receiving rehabilitation with a reduced service/no service - Increase in older people with reablement support - Length of stay in hospital (BCF) - Carers satisfaction - Unplanned admissions for chronic ambulatory care sensitive conditions (BCF)
Care & nursing homes	- We will strengthen our support and offer to care and nursing homes through our enhanced health in care homes programme, including homes with residents with a learning disability or dementia - Support care homes to meet digital requirements to connect to a shared care record and work with care homes to ensure they develop their workforce digital capabilities	- Care homes are more digitally integrated across health and social care - Less unnecessary conveyancing to hospital for care home residents	- Professionals and residents able to access a shared care record which includes care home data - Reduced hospital admissions from care homes
Falls prevention	- Reconfigure Falls Prevention service by establishing a falls network with more evidence-based prevention programmes in voluntary sector and community settings – supported by St Georges Hospital Community Therapy specialist service	- Improve the scale and reach of falls prevention service by working in partnership with the voluntary sector to deliver more services in the community. - Improved referral pathways between specialist service and VCS	- Increase in number of falls services and exercise classes delivered in the community by VCS groups. - Reduction in the number of falls in people age 65 and over

Digital	- We will embrace innovation and the use of digital technology to support residents to live the best life they can for as long as possible and reduce social isolation - Work with the voluntary sector to tackle digital inclusion, as well as ensuring that residents on packages of care are also supported to receive the training that they need to use technology and stay independent. Includes training sessions dedicated to helping service users stay safe online.	- Increase in the number of older adults using the internet to access online services that can help them stay independent - Reduction in people who feel lonely and socially isolated	- Number of older residents on line and receiving training to support them to use effectively - Increase in the number of older service users who have enough social contact
Supporting unpaid carers	- Improve the recognition of young carers and develop a range of support options including within school and learning environments. - Improve the recognition and identification of carers by GPs and increase the use of social prescribing. - Support carers to stay well and look after themselves and be socially connected with their community.	- Carers are better supported in their caring role and have access to a range of support options. - Young carers are better supported educationally, emotionally and physically. - Carers experience improvements in their physical and mental health wellbeing.	- Feedback from carers and users

7. Delivery and governance

a. Engagement and measuring impact

The development and delivery of the Wandsworth Health and Care Plan is overseen by the Wandsworth Health and Care Board, key partnership board which meets monthly and is co-chaired by the Managing Director of the CCG and the Chief Operating Officer of the local community service provider. All major providers and commissioners of health and social care in Wandsworth are represented on the group

Publishing this plan won't be the end of the conversation and we want to work together with local people and community organisations to put these plans into action.

Include people who use services and carers as experts by experience. Draw on powerful stories and insights. Since the success or failure of the programme will be judged on local experience of joined up care, transformation plans should be built on the experience of local people.

We want to design a monitoring framework collaboratively, so that we can collectively hold ourselves to account on delivery.

We will commit to regular communications and update so that all stakeholders can track and monitor progress against the plan.

We will

- Create and share a clear and common language that will be used in all communications. Everyone involved in delivering the plan should adopt this shared language and use it to disseminate messages.
- Revisit the narrative frequently to help ensure that people adopt the shared language and test it on people who use services and staff. Opportunities could include partnership meetings, multidisciplinary teams, community engagement events, team meetings and training sessions.
- Use joint and clear branding of all information, avoiding jargon and acronyms