THE SUTTON HEALTH AND CARE PLAN

Contents

1. Introduction

The Sutton Plan sets the strategic direction and ambitions of Sutton Council (the Council) and Sutton Clinical Commissioning Group (CCG) to deliver better health and wellbeing outcomes for local residents by working closely with a wide range of stakeholders, local people and carers who use services in Sutton.

Work has been undertaken over the past year by the Council, CCG, community and voluntary sector and Healthwatch Sutton, with the assistance of the South West London Alliance, to look at what is important for health and care in Sutton over the next five years, what the challenges are, and how different organisations can work even more closely together to make a sustainable difference for Sutton residents.

Our aspiration is that people of Sutton are supported to *start well*, *live well* and *age well* through a more personalised and joined-up approach to the delivery of health and care services in Sutton. Local leaders have come together through the Sutton Local Transformation Board to develop a Sutton Health and Care Plan that:

- sets out our joint approach and some of the improvements we will be working to achieve over the next five years.
- forms a foundation for how we will start to deliver against the priorities and requirements in the recently published NHS long-term plan, including how we:
  - move to a new way of working in Sutton through the establishment of an Integrated Care Place with partners in Sutton working together to define and drive the strategy and transformation plans that will ensure that the right care is delivered in the right place for local residents.
  - implement the NHS Personalised Care model for people of all ages and their carers so that people have choice and control over the way their care is planned and delivered, based on 'what matters' to them and their individual strengths and needs
  - ensure we deliver services with a strong focus on self-care, health promotion and prevention.
  - tackle the social determinants of health and reduce health inequalities.
  - integrate health, care and community and voluntary sector services, where it is right to do so, to support Sutton to be financially and clinically sustainable.

2. Our Health and Care partnership and joint vision

In Sutton our local health and care partners are:

- Community Action Sutton
- Community and voluntary sector partners including AgeUk Sutton, Sutton Parents Forum, Sutton Carers Centre
- Epsom and St Helier University Hospitals NHS Trust
- Healthwatch Sutton
- London Borough of Sutton
- NHS Sutton Clinical Commissioning Group
- South West London and St George's Mental Health NHS Trust
- South West London Health and Care Partnership
- Sutton GP Services Limited
- Sutton (London Borough) Public Health
- The Royal Marsden NHS Foundation Trust

As partners our shared vision for the future of Sutton as stated in The Sutton Plan is that:

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.

We have agreed to work together to deliver this vision by promoting 3 key strategic priorities:

- a better quality of life and opportunity for all residents.
- places underpinned by inclusive and sustainable growth.
- a coherent system of health and care that is shaped around the needs of Sutton's residents.

Our Sutton Health and Care Plan builds on the third priority and the commitments that underpin it, which are to:

- collaborate on a better system of health and social care that provides responsive, seamless, personalised and affordable services for all of those that need them - reducing the need for expensive in-hospital care.
- further promote single point of access services that are easy to navigate and offer the right care at the right time.
- build upon existing initiatives to increase individual and community resilience.

In delivering our Sutton Health and Care Plan we will continue to aspire to achieving transformational change by following our five partner principles:

- One - think Sutton first
- Two - work across sectors
- Three - get involved early
- Four - build stronger, self-sufficient communities
- Five - provide coordinated, seamless services

3. Our health and care challenges

The health of people in Sutton is generally better than for England overall. Deprivation is lower than average although there is wide variation within the borough. Life expectancy for both men and women is higher than for England. Although, life expectancy is 6.9 years lower for men and 5.9 years lower for women in the most deprived areas of Sutton than in the least deprived areas and about 12% of children (4,800) live in low income families.

The population of Sutton borough is growing. It is predicted that by 2022 it will have increased by around 14% since 2012. Our local communities are becoming more diverse, particularly the younger age groups.

Levels of GCSE attainment, breastfeeding initiation and smoking at time of delivery are better than the England average, as are rates of statutory homelessness, violent crime, early deaths from cardiovascular diseases and the percentage of people in employment. Sutton has fewer people dying prematurely from conditions that could be avoided such as circulatory disease.

The rate of excess winter deaths is worse than average, and other deaths could be prevented through better lifestyle choices on smoking, alcohol, physical activity and diet.

Our challenges

There are a number of challenges facing health and care services in Sutton that are preventing us from delivering better outcomes for our population Some of the key challenges that are affecting the ability of people to start well, live well and age well in Sutton are highlighted below.

Start Well

- *It is estimated that 8.5% of young people in Sutton aged 5-16 years have a mental health condition[1]*
- *The rate of hospital admissions as a result of self-harm in Sutton is above the London average (but similar to England)[2]*
- *A recent survey of young people in Sutton found that most of the respondents spend 3-4 hours a day viewing an electronic screen[3]*
- *The same survey revealed that the most common stresses in their lives are: exams, sleep problems, issues of body image and bereavement[3]*
- *4.8% of 15 year olds in Sutton reported using cannabis in the last month (similar to London and England)[4]*

[1] Public Health England, Fingertips https://fingertips.phe.org.uk/profile-group/mental-health/profile/cypmh/data#page/0/gid/1938132960/pat/6/par/E12000007/ati/102/are/E09000029

[2] Public Health England, Fingertips https://fingertips.phe.org.uk/search/self%20harm#page/4/gid/1/pat/6/par/E12000007/ati/102/are/E09000029/iid/21001/age/1/sex/4

[3] Healthwatch Sutton Young People's Mental Health and Wellbeing Survey Report January 2019 http://www.healthwatchsutton.org.uk/children-and-young-peoples-mental-health

[4] Public Health Fingertips https://fingertips.phe.org.uk/search/cannabis#page/0/gid/1/pat/6/par/E12000007/ati/102/are/E09000029/iid/91809/age/44/sex/4

- *Special educational needs include a range of learning difficulties or disabilities that make it harder for a child or young person to learn.*
- *More than 2,500 primary school aged children in Sutton have special educational needs (SEN).*[1]
- *More than 1,700 secondary school aged children in Sutton have special educational needs (SEN). This number has increased over the last 3 years.*[2]
- *Parents and carers need easy access to advice and support and families whose children have more complex needs require a coordinated approach from education, health and social care.*

[1] Public Health England Fingertips
https://fingertips.phe.org.uk/search/SEN#page/4/gid/1/pat/6/par/E12000007/ati/102/are/E09000025/iid/90838/age/215/sex/4
[2] Public Health England Fingertips
https://fingertips.phe.org.uk/search/SEN#page/4/gid/1/pat/6/par/E12000007/ati/102/are/E09000025/iid/90838/age/216/sex/4

Sutton is a great place to start and raise a family with a good range of support services and excellent schools. However, we are aware that not every family and child is thriving in Sutton. We want to raise the bar and tackle this inequality by addressing three main areas of concern:

- School readiness
  - We know that not enough of our children are ready for school by the time they reach their reception year. This means 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 this is important as a child who hasn't benefited from the right level of emotional support at home 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.
  - We have heard the concerns of educational colleagues about increasing demand being put on teaching staff and, worryingly we know that many of these children fall behind at both primary school and secondary school; which has a huge impact on their chances in life.

- Children with Special Educational Needs and Disability (SEND)
  - Another inequality that we have to tackle is the need to maximise chances for children with SEND. 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.

- Finally, we know that earlier detection of developmental delay and needs? can facilitate earlier intervention and better long-term outcomes for many conditions. We therefore need to explore how we can redesign pathways to improve rates of early detection and intervention.

- Mental wellbeing for young children
  - 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.
  - This is creating challenges in addressing an unmet need around mental wellbeing for young children in the borough.
  - This is an issue that is beyond the remit or capacity of any one single agency to address. However, the recent trailblazer mental health school support team aimed at providing support for children points to the ability for partners to collaborate together to address this complex issue.

Live Well

Supporting adults with learning disabilities

- *People living with learning disabilities are a diverse group and the support that they require will vary based on their particular needs.*
- *64.1% of adults with a learning disability have an annual GP health check in Sutton, which is higher than the national average.[1]*
- *Supported working age adults in Sutton, who have a learning disability, are less likely to live in settled accommodation or be in paid employment than the national average.[2]*
- *It is estimated that there will be a 19% increase in the number of people with a learning disability by 2030. The largest increase will be in people aged 85 years and over due to improved life expectancy.[3]*

1 Public Health England, Fingertips
https://fingertips.phe.org.uk/search/learning%20disability#page/4/gid/1/pat/6/par/E12000007/ati/102/are/E09000029/iid/93183/age/1/sex/4
2 Public Health England, Fingertips
https://fingertips.phe.org.uk/search/supported%20working%20age%20adults#page/0/gid/1/pat/6/par/E12000007/ati/102/are/E09000029
3 PANSI https://www.pansi.org.uk/

Encouraging adults to make healthy lifestyle choices

- *Although people are living for longer they spend more years in poor health and each year people die early from diseases that are considered preventable*
  - *12.8% of adults in Sutton smoke – similar to the national average[1]*
  - *1.7% of adults in Sutton cycle for travel at least 3 days per week, which is lower than the national average[2]*
- *There are many benefits of adopting a healthy lifestyle and lots of easy ways to incorporate these changes into a daily routine*
- *Lots of people are already taking advantage of the assets we have in Sutton e.g. each week 700 people take part in the Nonsuch Park run*

1 Public Health England, Fingertips
https://fingertips.phe.org.uk/search/smoking%20in%20adults#page/4/gid/1/pat/6/par/E12000007/ati/102/are/E09000029/iid/92443/age/168/sex/4
2 Public Health England, Fingertips
https://fingertips.phe.org.uk/search/cycle%20for%20travel#page/4/gid/1/pat/6/par/E12000007/ati/102/are/E09000029/iid/93440/age/164/sex/4

Supporting carers

Nationally we know that carers who:

- *found it hard to access information were less satisfied with the services they received*[1]
- *felt socially isolated were more likely to report that they felt they had no support or encouragement*[1]
- *didn't have as much social contact as they wanted and couldn't do things, they enjoy felt they had less control over their lives*[1]

1 Personal Social Services Survey of Adult Carers in England, 2018-19: Report
https://digital.nhs.uk/data-and-information/publications/statistical/personal-social-services-survey-of-adult-carers/england-2018-199

Although there is a wide range of local services for people living with a learning disability in Sutton, we know that we need to do more to address inequalities that persist both in terms of purposeful employment but also in terms of the health inequalities that persist e.g. the current national life expectancy for women and men with a learning disability is still 18 years and 14 years lower than their respective counterparts in the general population.

We also know that far too many of us lead sedentary and unhealthy lifestyles and, while this has become normal, this means that around 65,000 people in Sutton have developed a major long-term condition such as diabetes or high blood pressure. In turn these conditions have become 'medicalised' in the sense that society feels that these conditions can be simply dealt with through a pill prescribed by the GP.

However, the evidence suggests that medical therapy is not more effective than making sustainable changes to our lifestyles. Many of these long-term conditions are preventable as are their serious long-term complications, both for residents and the health and social care system. Given escalating costs and poor outcomes there is an imperative to do something different in terms of helping primary care to improve quality around long-term conditions management and prioritise primary prevention.

This however also needs to align to a better offer to residents to improve their physical and emotional health. We need to consider public and community assets such as parks and open space and explore how these might be better used to support self-care initiatives to help residents take control of their lives through initiatives such as Park Run, outdoor gyms or community gardens.

We know and recognise that unpaid carers are critical to the provision of care and support to adults in Sutton. 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 well-being 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 2 of the ways to achieve improved outcomes for carers is to:

- improve 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

Age Well

GPs see older people, many of whom are widowed, who have multiple health problems like diabetes, hypertension and depression, but often their main problem isn't medical, they're lonely.

- *In Sutton 59% of people who use social care services reported that they do not get as much social contact as they would like[1]*
- *In Sutton 71.8% of adult carers reported that they do not get as much social contact as they would like[2]*

Older people's health and care needs often become more complex as they age. Managing these challenges requires an integrated, holistic approach from the organisations involved in their care. This is particularly important when people leave hospital

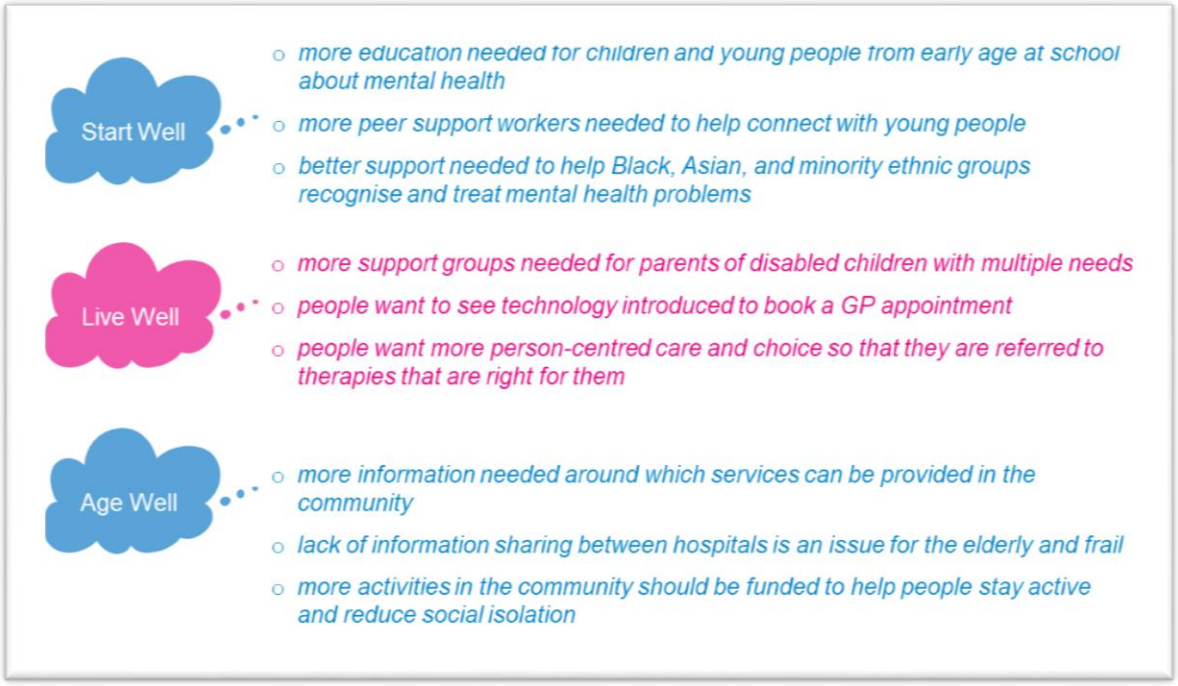
1 Public Health England, Fingertips
https://fingertips.phe.org.uk/search/social%20care%20services#page/4/gid/1/pat/6/par/E12000007/ati/102/are/E09000029/iid/90280/age/168/sex/4
2 Public Health England, Fingertips
https://fingertips.phe.org.uk/search/social%20care%20services#page/4/gid/1/pat/6/par/E12000007/ati/102/are/E09000029/iid/90638/age/168/sex/4

We know from many examples nationally that building the link between primary care and the wider community offer is key to improving not just physical wellbeing but also to addressing emotional wellbeing. Just as we need to have schemes to prescribe exercise, we also need to take advantage of national investment to promote social prescribing which is particularly important to tackle social isolation.

In the future, social prescribing link workers could engage residents from the GP practice into community interventions to help them with their physical, emotional and social wellbeing, thereby reducing demands on a stretched system but also giving back control and focus to the individual resident as opposed to leaving it to the hands of the professional.

Feedback from residents of Sutton

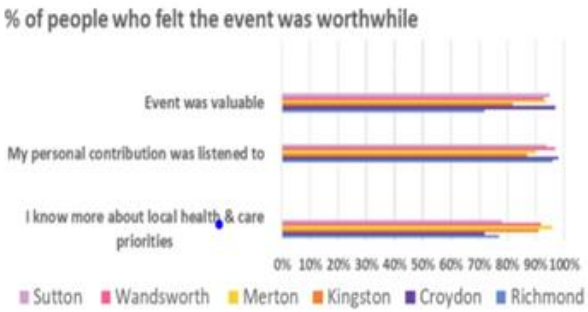
Previous engagement in Sutton also identified some challenges that people felt needed addressing. Some of the feedback provided across the three areas of Start Well, Live Well and Age Well is shown below.



This feedback was reinforced at the Sutton Health and Care deliberative event held on 29th November 2018, which was attended by about 120 people with representation from residents (as users and/or carers), and stakeholders across health, social care, and community and voluntary sectors including AgeUK Sutton, Sutton Parents Forum, Sutton Carers Centre and Volunteer Centre Sutton. A summary overview of the key messages and feedback received from the event is shown below.

Sutton Health and Care Plan

Borough event to engage on our local health and care plan



Attendees

This event had c.130 attendees. One third members of the public, one third staff and one third stakeholders.

- Hosted by Health and Wellbeing Board Chair
- Demographically reflective sample of local people
- Community and stakeholder groups

THE SUTTON PLAN

4. Our case for change

There is a real sense of ambition and desire by Sutton partners to build on the strength of our established partnership. We want to move forward in accelerating our journey of integration to enable us to rise to the dual challenges of improving care for residents and maintaining financial balance across the Sutton Health and Care system.

Many of the challenges that we have highlighted above are beyond the remit of any single organisation to address fully. We therefore believe that system-wide efforts are needed to produce the sustainable transformative change needed to improve care.

This will be driven by the development of an Integrated Care Place that will provide us with a collaborative strategic framework to align our resources to focus on shared local priorities that for example:

- improve quality by reducing unwarranted variation wherever it exists
- deliver a multi-agency approach that improves earlier intervention thereby reducing the need for statutory interventions
- improve the quality of advice and support offered to families of children with Special Educational Needs and Disability, and people with Learning Disabilities

Our service delivery model will also have to be further enhanced to ensure maximise impact. This will be driven by the expansion of the multi-organisational Sutton Health and Care Alliance as the joint service delivery vehicle. This will provide a focused approach in developing and delivering cost effective integrated services (e.g. planned care, continuing health care, end of life care) that address the identified challenges.

The following sections therefore set out how we will address these system-wide challenges over the next five years.

5. Our Sutton Health and Care Plan

A high-level overview of our plan is shown below and highlights the strategic approach, priorities, initiatives and benefits we will be looking to achieve.

SUTTON HEALTH AND CARE PLAN VISION
A thriving Sutton for Everyone

REFORM PRINCIPLES
· Think Sutton first · Work across sectors · Get involved early · Build stronger, self-sufficient, communities · Provide coordinated, seamless services

STRATEGIC APPROACH

A commitment to establishing an Integrated Care Partnership through:

- Development of an Integrated Care Place.
- Commitment to aligned commissioning between London Borough Sutton and Sutton CCG.
- Expansion of the Sutton Health and Care Alliance for provision of children and adult community services.
- Further development of Primary Care at Scale and Primary Care Networks within Sutton.
- Further integration between health and social care through multidisciplinary teams delivering services through networks.
- Undertaking Outcome Based Commissioning Reviews.
- Expansion of the compassionate communities' approach within Sutton.
- Engagement as partners in Improving Healthcare Together 2020-30.

STRATEGIC PRIORITY

A coherent system of health and care that is shaped around the needs of Sutton's residents

Our Sutton Health and Care Plan priorities to achieve this will be to:

Start Well
- improve young people's mental health.
- improve the support provided to parents of children with Special Educational Needs and Disability.
- develop the universal offer to make sure all children are ready for school regardless of their socioeconomic status.

Live Well
- improve the specialist care support provided for adults with learning disabilities.
- improve how we encourage adults to make healthy lifestyle choices.
- improve the support for people with both a long term physical and mental health condition.

Age Well
- improve how we combat loneliness and social isolation among older people.
- improve how we support older people when they leave hospital.

SUTTON HEALTH AND CARE PLAN INITIATIVES

Start Well – we will
- Implement a trailblazer enhanced mental health support pilot for children and young people in schools.
- Continue the perinatal and infant mental health network with new projects on infant mental health, patient and public engagement, and fathers and partners.
- Undertake a joint health and local authority review of our children's services by focusing on three key areas:
  - school readiness.
  - emotional wellbeing.
  - early intervention for children with Special educational Needs and Disability.
- Review and redesign the information and support offer for parents of children with Special Educational Needs and Disability.

Live Well – we will
- Undertake a joint health and local authority review of how we commission services for people with Learning Disabilities in Sutton.
- Review and redesign the information and support offer for people with learning disabilities.
- Use population health intelligence to more effectively identify and target interventions and services for people living with a long-term condition.
- Work with residents, community groups, organisations and schools to promote healthy lifestyles.
- Improve the link between Primary Care and community assets to further support self-care.
- Implement the integrated Improving Access to Psychological Therapy - long term condition service model.
- Implement a Planned Care transformation Programme.

Age Well – we will
- 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.
- Extend the provision of social prescribing through voluntary sector organisations in Sutton.
- Extend the development of our Sutton Health and Care programme through implementation of a proactive model of care.
- Further integrate pathways across Sutton Health and Care At Home service.
- Redesign the falls model.
- Expand delivery of the Sutton End of Life care model for individuals in the last 12 months of life.
- Progress the "Working Together" functional review for delivery of continuing health care.

SUTTON HEALTH AND CARE PLAN BENEFITS

Start Well – include
- decreased incidence of self-harm in children and young people.
- improvements in mental health and resilience measures.
- experts by experience are part of the network and support work streams.
- services/interventions are developed to support the needs and wellbeing of fathers and partners in the perinatal period.
- increased awareness of local services offers and assets.
- improved access to community resources and services leading to increased independence and satisfaction.
- improved experiences for children with Special Educational Needs and Disability and their families.

Live Well – include
- improved experiences for people with learning disabilities and their families.
- a streamlined, single point of access, information and advice offer for all residents, including people with learning disabilities.
- increased physical activity.
- improved health and wellbeing outcomes.
- improved ability for people with long term condition to benefit from Improving Access to Psychological Therapy interventions.
- closer collaborative working between mental and physical health services.
- Improved waiting times for planned care

Age Well – include
- reduced social isolation.
- increased physical activity.
- improved physical and mental health outcomes.
- positive intergenerational relationships.
- strengthened community capacity.
- provision of an evidence-based fall model
- improved non-medical support for people.
- improved health and wellbeing outcomes.
- improved use of capacity in primary care through greater self-care and increased use of alternative services.

Our strategic approach

As Sutton partners we have a commitment to establishing an Integrated Care Partnership that drives and owns our strategic health and care plans. Some of the ways in which we will work to deliver this will be through:

- Development of an Integrated Care Place
  - There are a number of organisational changes taking place within the NHS in response to the priorities set out in the NHS Long Term Plan. This includes:
    - the 6 South West London CCGs coming together to form a single South West London CCG (an Integrated Care System) by April 2020 with full NHS financial accountability for the system
    - development of a new Sutton Integrated Care Place that will have delegated financial accountability at the local borough level for the majority of the current NHS budgets, to reshape and deliver services at borough level
  - As system leaders across health, social care and the voluntary sector in Sutton we have already been working together over the past year through the Local Transformation Board in defining and driving local strategy and transformation plans. We are therefore building on our existing governance arrangements and joint working successes to develop the new Sutton Integrated Care Place in 4 stages so that we:
    - deepen our shared strategic vision and intent
    - further align our joint strategic planning
    - free up provider partners to respond as one alliance to the Health and Care Plan

One Vision	• Through the **Sutton Plan** and the principles within it to integrate health and care services to deliver better outcomes for the people of Sutton
One Plan	• Through the **Sutton Health and Care Plan** and the strategic priorities for health and care
One Service Delivery Model	• Through **Sutton Health and Care as the Alliance provider** that develops and delivers against a service development map that responds to the health and care plan

- **Stage 1 – Establishment of a Sutton Health and Care Executive to develop the Health and Care Plan, by:**
  - reshaping the Local Transformation Board to a new Health and Care Executive that develops the Health and Care Plan, and is dually-accountable to the Council through the Health and Wellbeing Board (ensuring delivery against the Sutton Plan vision) and to the new South West London CCG (ensuring the NHS Long Term Plan national priorities are being delivered)
  - ensuring that the Council and CCG plan their financial investment in accordance with the joint Health and Care Plan, through an "aligned" approach to budgeting which preserves the necessarily distinct governance and accountability systems of the NHS and Council.
  - annual review of the plan to ensure key strategic requirements are being met and that the plan continues to be developed by commissioners and providers together as a whole system instead (instead of the traditional commissioner/provider "split")
- **Stage 2 - Sutton Health and Care (the Alliance Provider) shaping a service development map to deliver the Health and Care Plan, by:**
  - producing a 5-Year service development map (reviewed annually) that sets out how the strategic requirements will be delivered including for example:
    - priorities for transformation/redesign
    - service delivery models
    - which services will be delivered by the Alliance and/or through contracts with other non-partner providers such as the community and voluntary sector, schools etc
    - how these will support the NHS financial recovery and efficiency programme
- **Stage 3 – Service delivery through an Integrated Provider Contract(s) where it makes sense to do so, by:**
  - in the first instance procuring integrated services through an appropriate Integrated Provider NHS contract(s) that is delivered alongside other aligned contracts e.g. Council contracts for social care and/or education components of the integrated services
  - working together over time as the local system

matures and national legislation changes towards potentially procuring a single integrated NHS and Council contract for delivery of integrated services

- **Stage 4 – Establishment of a single peer review assurance process for the delivery of integrated services, by**
  - moving away from current multiple transactional contract reviews with individual providers to a more holistic single system approach that uses joint intelligence, quality improvement methodologies and lived experiences to review and improve services

- **Commitment to aligned commissioning between London Borough Sutton and Sutton CCG**
  - As local partners we have developed a Health & Social Care Integration programme that brings together what we are jointly commissioning and/or working to deliver, to ensure we can deliver better outcomes for people through a joined-up service planning and commissioning approach.
  - This provides a strong foundation for moving forward together in shaping and developing the Integrated Care Place for Sutton, through joint strategic discussions that are focused around the Sutton Plan, the Sutton Health and Care Plan, and the NHS Long Term Plan.

- **Expansion of the Sutton Health and Care Alliance for provision of children and adult community services**
  - London Borough of Sutton and Sutton CCG commissioners have commissioned adult community service, and an integrated children's community service on an interim basis over the next two years from the Sutton Health and Care Provider Alliance that was established in April 2018 and comprised of the following local partners:
    - Epsom and St Helier University Hospitals NHS Trust
    - London Borough of Sutton
    - South West London & St Georges Mental Health NHS Trust
    - Sutton GP Services Limited
  - This arrangement provides both commissioners with service continuity, time to implement new models of care with services shaped around people in a more integrated way, to re-procure community services that are fit for purpose in the future.
  - The provision of children and adult community services by the alliance will build on the provision of the integrated Sutton Health and Care at Home service established on 1st April 2018.

- **Further development of Primary Care at Scale and Primary Care Networks within Sutton**
  - Sutton will continue working with GP Practices within Sutton and Sutton GP Services Limited (our GP federation) to further develop joint working between practices at both network and borough

levels to meet the requirements of the NHS Long Term Plan commitments. This will include multidisciplinary teams within Primary Care supporting delivery of:

- enhanced access to Primary Care services that supports the delivery of urgent care in the community.
- improved access to digital technologies that enhance the ability of people and clinicians to access and provide care.
- proactive personalised care planning, and anticipatory care provision for high need patients typically with several long-term conditions.
- structured medication reviews to support improved medicine optimisation and safety.
- early cancer diagnosis
- enhanced health provision in care homes

- **Further integration between health and social care through multidisciplinary teams delivering services through networks**
  - Sutton has been progressing the implementation of a locality hub within Wallington with teams from community health services and London Borough of Sutton adult social services co-located to support:
    - a joint approach to assessments and care planning with clear roles and responsibilities - "make one visit count".
    - understanding of what additional professionals could further enhance the provision of care within localities.
  - The learning from this first phase will be used to inform the development of wider integrated primary, community and social care multidisciplinary teams aligned to the new Primary Care networks that support people to maintain their independence.
  - These expanded teams are likely to include GPs, community geriatricians, allied health professionals like physiotherapists, district nurses, mental health nurses, and reablement teams working together to deliver the NHS Long Term plan commitments for improved community crisis response, reablement and proactive personalised care provision.

- **Undertaking Outcome Based Commissioning Reviews**
  - The council's outcome-based commissioning reviews are a coordinated partnership approach to achieve the best outcomes for residents in the context of the significant £22m of savings which need to be made by the Council. Rather than simply slashing budgets the reviews will provide a mechanism for the Council to work with wider partners and to identify the best way to maximise value for residents focusing on four key outcomes: Being Active; Making Informed Choices; Living Well Independently and Keeping People Safe.

- The first two of these reviews are underway and will have significant interlinkages with the Sutton Health and Care Plan for individuals and/or their carers around for example social prescribing to support issues of isolation, supporting and enabling people to more easily access information, and improving physical wellbeing.
- Similarly, Sutton CCG and Epsom and St Helier Hospital Trust are working together to achieve a financial sustainable health system by developing new models of service delivery with particular focus on delivering services in out of hospital settings. This along with the outcomes-based commissioning reviews is important to ensuring we get the best out of the Sutton pound for local people.

- Expansion of the compassionate communities' approach within Sutton
  - In a compassionate community, people are motivated to take responsibility for and care for each other. A community where compassion is fully alive is a thriving, resilient community whose members are able to confront crises with innovative solutions, are confident in navigating changes in the economy and the environment and are resilient enough to bounce back.
  - We will support individuals, groups, and organisations to develop asset base approaches that enables them to develop the tools and capacity to create a Compassionate Community.
  - The asset-based approach will be designed by a diverse and inclusive coalition of people so that all voices within the community are heard, and the issues of importance to them are addressed.

- Engagement as partners in Improving Healthcare Together 2020-30
  - The Improving Healthcare Together Programme is led by the three Clinical Commissioning Groups of Sutton, Merton and Surrey Downs with the full support and engagement of Epsom and St Helier University Hospitals NHS Trust.
  - The programme is working with all of the South West London providers, NHS regulators and the joint independent Clinical Senate from London and the South East to take this work forward.
  - A pre-consultation business case has been developed with engagement from the public, residents, patients, staff and the organisations representing them.
  - The programme plans to proceed to a public consultation once full engagement and assurance is provided by all the affected stakeholders and a final business case is approved by the three Clinical Commissioning Groups.

Our priorities, initiatives and benefits

Start well

Our priorities will be to:

- **improve young people's mental health**
- **improve the support provided to parents of children with Special Educational Needs and Disability**
- **develop the universal offer to make sure all children are ready for school regardless of their socioeconomic status**

We will do so by delivering the following initiatives:

- **Implement a trailblazer enhanced mental health support pilot for children and young people in schools, by**:
  - establishing a new team of school-based mental health support workers in a phased approach to support approximately 8,000 children across a number of schools in Sutton.
  - offering both one-to-one support and group work sessions for pupils and parents, and where needed, providing referrals to specialist children and adolescent mental health services.
  - designing sessions to give children and young people practical skills for managing a range of feelings and offer parents an opportunity to practise the conversations that encourage better mental health and wellbeing.
  - This will help us to achieve a number of benefits including:
    - decreased incidence of self-harm in children and young people.
    - improved access to mental health support services by children and young people from Black, Asian, and minority ethnic groups.
    - improvements in mental health and resilience measures.
- **Continue the perinatal and infant mental health network (PIMH) with new projects on infant mental health, patient and public engagement, and fathers and partners by:**
  - working with the Parent Infant Mental Health task and finish group to address gaps in provision and to identify opportunities for further collaboration.
  - working with the Support for Fathers and Partners task and finish group to look at how community assets (e.g. groups, physical places etc) can better support this group.
  - working with Healthwatch Sutton to engage further with parents and to develop more experts by experience.
  - supporting the New South West London Specialist Perinatal Mental Health service for mothers with moderate to severe mental health needs.
  - This will help us to achieve a number of benefits including:

        - Parents being able to access a service for infants at risk of mental health issues or/and risks to their brain development to address needs/concerns identified.
        - parents and families including those from seldom heard groups and Black, Asian and minority ethnic communities engaged in testing out pathways and access to services.
        - experts by experience are part of the network and support work streams.
        - services/interventions are developed to support the needs and wellbeing of fathers and partners in the perinatal period.

- **Undertake a joint health and local authority review of our children's services, by:**
    - focusing on three key areas:
        - School readiness
        - Emotional wellbeing
        - Early intervention for children with SEND
    - ensuring the review includes health, education, the council and voluntary sector partners and uses an outcomes-based approach to look at understanding current need, assets, pathways and their effectiveness before looking at local and national evidence of what works.
    - making sure the reviews tackle questions such as:
        - how do we ensure better outreach for universal services to the most vulnerable?
        - how do we provide better earlier interventions to improve parenting skills and early literacy?
        - how do we detect developmental delay sooner?
        - how do we realign resources to meet the emotional needs of young people?

    - This will help us to achieve a number of benefits including:
        - better universal support for families around emotional wellbeing and parenting to improve rates of school readiness.
        - earlier intervention for children with developmental delay / SEND.
        - better use of resources to support more children with SEND in mainstream schools.
        - more young people supported at school or in the community around their emotional wellbeing

- **Review and redesign the information and support offer for parents of children with Special Educational Needs and Disability (SEND) by:**
    - being included within the scope of the Making Informed Choices Needs Assessment, which will include:
        - completing a needs assessment, to identify the needs of the cohort and demand for the services.

        - setting out a strategic direction in the commissioning plan which will identify and assess the potential options that are available to meet the identified needs.
        - implementing the agreed recommendations.
        - reviewing the implemented model to assess whether it is meeting the identified needs and the desired impact.
    - strengthening the advice, guidance and support provided by the SEND health team.
    - ensuring the designated clinical roles are supporting partnership working and improving care and outcomes for children.

    - This will help us to achieve a number of benefits including:
        - increased awareness of local services offers and assets.
        - improved access to community resources and services leading to increased independence and satisfaction.
        - improved experiences for children with Special Educational Needs and Disability and their families.

Live well

Our priorities will be to:

- improve the specialist support provided for adults with learning disabilities
- improve how we encourage adults to make healthy lifestyle choices
- improve the support for people with both a long term physical and mental health condition

We will do so by delivering the following initiatives:

- Undertake a joint health and local authority review of how we commission services for people with Learning Disabilities in Sutton by;
    - carrying out a review of Health Outcomes identified through the Learning Disability Health Summit 2017 and the Joint Learning Disability Strategy 2017, and formulating a plan to deliver person centred, community focused, integrated resources for Sutton residents.
    - assessing the function, structure and outcomes relating to the Learning Disability Community Health Team, with a change and improvement plan to be created in order to deliver associated outcomes.
    - considering options for the delivery of an aligned commissioning structure across the Health and Social Care economy to improve efficiency and to achieve associated joint outcomes for Sutton residents
    - developing an agreed Learning Disability Joint commissioning plan.
    - creating a Learning Disabilities Specific Joint Market Position Statement that is co-produced with providers, businesses and residents so that the local market is prepared to provide the services and opportunities required and wanted by people with learning disabilities in Sutton.
    - This will help us to achieve a number of benefits including:
        - improved experiences for people with learning disabilities and their families.
        - improved access to community resources and services leading to increased independence and satisfaction.
        - a more sustainable, affordable and appropriate model of health and care for this population.
- Review and redesign the information and support offer for people with learning disabilities by:
    - being included within the scope of the Making Informed Choices Needs Assessment, which will include:
        - completing a needs assessment, to identify the needs of the cohort and demand for the services.
        - setting out a strategic direction in the commissioning plan which will identify and assess the potential options that are available to meet the identified needs.
        - implementing the agreed recommendations.

        - reviewing the implemented model to assess whether it is meeting the identified needs and impact.

    - This will help us to achieve a number of benefits including:
        - improved experiences for people with learning disabilities and their families.
        - improved access to community resources and services leading to increased independence and satisfaction.
        - a streamlined, single point of access, information and advice offer for all residents, including people with learning disabilities.

- **Use population health intelligence to more effectively identify and target interventions and services for people living with a long-term condition by:**
    - working with NHS England to embed the national cardiovascular disease prevention audits
    - improving access to real time data so that GPs, practices and networks can understand opportunities to improve care for patients and populations.
    - using audit to systematically identify individuals whose high-risk conditions are sub-optimally managed, either through non-diagnosis, under treatment or over treatment.

    - This will help us to achieve a number of benefits including:
        - improved outcomes for patients and communities (prevention of heart attacks, strokes and cases).
        - improved uptake of treatments proven to manage high risk conditions for cardiovascular disease.
        - an evidence base for establishing new models of care and care pathways.
        - Supporting improved work flow through primary care networks to engage the skills of pharmacists, nurses and the wider primary care workforce.

- **Work with residents, community groups, organisations and schools to promote healthy lifestyles by:**
    - undertaking a Being Active Outcome Based Commissioning Review with key stakeholders to identify and agree outcomes and interventions for increasing physical activity and encouraging healthy living.

    - This will help us to achieve a number of benefits including:
        - increased physical activity.
        - improved health and wellbeing outcomes.

- **Improve the link between Primary Care and community assets to further support self-care by:**
    - being included within the scope of the Making Informed Choices and Being Active needs assessments, which will include:
        - completing a needs assessment, to identify the needs and demand for the services.
        - setting out a strategic direction in the

commissioning plan which will identify and assess the potential options that are available to meet the identified needs.
    - implementing the agreed recommendations on how to best support and navigate people from primary care to advice and services available for self-care.
    - reviewing the implemented model to assess whether it is meeting the identified needs and the desired impact.

  - This will help us to achieve a number of benefits including:
    - improved access to community resources and services leading to increased independence and satisfaction.
    - improved health and wellbeing outcomes.

- Implement the integrated Improving Access to Psychological Therapy (IAPT)-long term condition (LTC) service model by:
  - expanding access to IAPT services that are integrated into primary care offering IAPT Cognitive Behaviour Therapy for people with long term conditions.
  - care professionals working as part of a multidisciplinary team, with therapists who have been additionally trained in IAPT-LTC providing NICE-recommended evidence-based treatments.
  - implementing the service in a phased approach starting with people with diabetes and Chronic Obstructive Pulmonary Disease.

  - This will help us to achieve a number of benefits including:
    - improved ability for people with long term condition to benefit from Improving Access to Psychological Therapy interventions.
    - improved health and wellbeing outcomes.
    - improved patient choice (where applicable) of the type of intervention required.
    - closer collaborative working between mental and physical health services.

- Implement a Planned Care transformation programme by:
  - delivering Planned Care initiatives that will encompass a complete transformation of how outpatient services are used and delivered. This will cover all areas from demand management (minimising unwarranted variation wherever it exists) to usage of virtual triage, to maximising the usage of community resources to be able to deliver more care closer to home.

  - This will help us to achieve a number of benefits including:
    - improved access to community resources and services.
    - Improved waiting times for planned care.
    - improved health and wellbeing outcomes

Age well

Our priorities will be to:

- improve how we combat loneliness and social isolation among older people
- improve how we support older people when they leave hospital

We will do so by delivering the following initiatives:

- 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 by:
    - undertaking Making Informed Choices and Being Active Outcome Based Commissioning Reviews with key stakeholders to identify and agree outcomes and specific interventions which are likely to focus on:
        - increasing physical activity.
        - tackling social isolation.
        - developing community connections.
        - developing intergenerational support systems through, for example, buddies/ mentorship schemes.
    - This will help us to achieve a number of benefits including:
        - reduced social isolation.
        - increased physical activity.
        - improved physical and mental health outcomes.
        - positive intergenerational relationships.
        - strengthened community capacity.
- Extend the provision of social prescribing through voluntary sector organisations within Sutton by:
    - Sutton CCG and London Borough of Sutton working with Sutton GP Services Limited (our GP Federation), Sutton Uplift, Advice Link Partnership Sutton, and Healthwatch Sutton, to develop a model to support people particularly with issues that impact on their overall health and wellbeing e.g. social isolation, low mood, peer support, financial and housing issues.
    - ensuring the model provides a tailored approach based on the needs of the individual including access to advice and information, goal setting and coaching, and linking with community assets, depending on the needs of the individual.
    - expanding access of social prescribing to frail and vulnerable people through the establishment of network multidisciplinary team Social Prescribing Link workers, and to a wider range of people through the establishment of Primary Care Network Social Prescribing Link workers.
    - including the provision of social prescribing within the scope of the Being Active needs assessments, strategy development and procurement.
    - This will help us to achieve a number of benefits including:
        - improved non-medical support for people.
        - improved health and wellbeing outcomes.

        - improved use of capacity in primary care through greater self-care and increased use of alternative services.

- **Extend the development of our Sutton Health and Care programme through implementation of a proactive model of care by:**
    - establishing a proactive case management approach where frail and vulnerable people are proactively identified and supported through multidisciplinary care planning and management to improve quality of care and to reduce unnecessary hospital admissions or attendances.
    - establishing network-based multidisciplinary teams delivering personalised care where professionals from a range of services including General Practice, acute, community health and mental health, social care, pharmacy and voluntary sector, come together to make decisions regarding recommended treatment and support for a patient.
    - developing personalised integrated health and social care management plans that are electronically accessible when needed via Coordinate My Care for professionals who need to support those people in times of crisis.

    - This will help us to achieve a number of benefits including:
        - improved health and wellbeing outcomes.
        - increased patient activation and engagement in health-related activities.
        - reduced emergency hospital admissions
        - reduced A&E attendances.

- **Further integrate pathways across Sutton Health and Care At Home service by:**
    - enhancing relationships between the At Home Service and wider Sutton Health and Care Services through Primary Care Network development.
    - reviewing the At Home Service rapid response admission avoidance pathways and enhancing as required.
    - rolling out the Discharge to Assess model in a phased programme across all wards at St Helier Hospital.
    - reviewing the capacity and demand for community intermediate care beds provision including the use of B6 as a post-acute ward
    - continuing the roll out of the 'one team' ethos throughout the At Home Team and wider Sutton Health and Care services
    - enhancing the role of the third sector in supporting discharges and admissions avoidance.
    - using evaluation and learning from Sutton at Home service outcomes to inform future developments for adult community services.

    - This will help us to achieve a number of benefits including:
        - improved patient and carer experience.
        - optimising independence for people supported by the service.

        - more people spending more time at home
        - reduced emergency hospital admissions
        - reduced A&E attendances.
        - improved timely discharge for people who need to be admitted.

- Redesign the falls model by:
    - working together with key partners and wider stakeholders, to ensure falls prevention and management opportunities are maximised.

    - This will help us to achieve a number of benefits including:
        - provision of an evidence-based falls model
        - optimising independence for people supported with improved health and wellbeing outcomes
        - reduced A&E attendances, unplanned admissions and fractures
        - increased physical activity
        - stronger local partnerships with wider stakeholders

- Expand delivery of the Sutton End of Life care model for individuals in the last 12 months of life by:
    - building on the services provided by Sutton Health and Care Alliance with the additional involvement of St Raphael's Hospice to provide holistic support for patients and their families in the last 12 months of their life by delivering proactive case finding and/or early identification to prevent unnecessary hospital admissions as a result of:
        - using a Sutton GP Practice Palliative Care Register to support GP Practices in identifying people with and without cancer who may be in their last year of life, and to ensure that they have robust advanced care plans that are reviewed on a regular basis.
        - working with Hospital Specialty Teams such as palliative, respiratory and renal teams to identify patients who are in the last stage of life whose care require coordination in the community and at home.
        - working with Social Care (council funded and self-funders) to increase the identification of service users (receiving social funding and self-funders) who may not be visible to other health and social care professionals.

    - This will help us to achieve a number of benefits including:
        - patients identified as early as possible and offered advanced care plans that are accessible on Coordinate My Care.
        - improved patient and carer experience.
        - improved outcomes with people achieving death in their preferred place of residence.
        - reduced emergency hospital admissions.

- **Progress the 'Working Together' functional review for delivery of continuing health care by:**
  - completing the functional review that commenced in South West London in 2018/19 on how we commission continuing health care services that deliver the best benefits for people in Sutton and

  - This will help us to achieve a number of benefits including:
    - improved consistency in care delivery standards and processes

    across South West London, including consideration of which aspects of the service could be best delivered:
  - 'At scale' across South West London
  - 'At Place' with a local borough focus
  - 'At scale' with a borough focus
    - improved use of service capacity for patient support
    - improved capability and development of the workforce

6. The financial context of our plan

Good, sustainable and adaptive health and care services need to be underpinned by sustainable financial balance, however health and social care sectors both face significant financial challenges.

The health sector is in deficit and has been set challenging financial targets for the 2019/20 financial year. Both Sutton CCG and Epsom and St Helier University Hospitals NHS Trust incurred in year deficits in the 2017/18 and 2018/19 financial years and have underlying deficits.

The London Borough of Sutton, in common with other Local Authorities, has seen central government grant reductions and these are set to continue. 2019/20 is the final year of the '4 Year Settlement Offer' from central government which provided some certainty over the resource available to the Council. Central government are proposing and working with local government on a fair funding review and new approach to business rates retention which will fundamentally change local government finance.

In addition, this coincides with a challenging comprehensive spending review where central government has already committed a significant proportion of any increased funding available to protected areas. This will provide a challenging environment for local government and the Ministry of Housing Communities and Local Government to advocate for additional funding for local government, which is not a protected expenditure area.

Within the Council, consistent with the national picture, there has continued to be a high level of demand for Adult Social Care. Work to manage this demand has reaped benefits - however there still remains increasing demand within this area which is reflected in the budget and Medium-Term Financial Plan. Joint working within the "Health and Social Care" system is crucial to improve outcomes and achieve financial balance overall.
The Local Government Financial Settlement 2019/20 provided some additional funding for local government to partly help meet the significant funding pressures faced including for areas such as adults and children's services.

However, for Sutton as for other Local Authorities it did not bridge the gap between available resources and the funding needed to meet the increasing demands and cost of local government services. In addition to that, it is unclear what is going to happen after 2019/20 with this short-term funding.

Sutton Council's recommended revenue budget for 2019/20 in broad terms includes; £4.278m of inflation, £6.247m of service growth cost pressures (including children's safeguarding and adult social care); funded by £6.408m of proposed savings, a general increase in Council Tax of 2.99% that will raise £2.868m of funding, a further increase of 2.00% in Council Tax for the Adult Social Care Precept that will raise a further £1.917m, other general budget adjustments of £0.55m, pre agreed use of reserves of £2.000m, and a further use of reserves of £1.089m.

The Council financial plan over the next 3 years is even more challenging. After a balanced budget in 2019/20, additional

savings of £12.089m in 2020/21, £5.152m in 2021/22 and a further £4.706m in 2022/23 will be required to close the budget shortfall gap based on current information. Should any of the current factors change, resulting in additional cost pressures or loss of further funding, then potentially further savings will be needed. The proportion of these additional savings to be allocated to Adults Service will depend on the budget setting process, the outcome of the "Outcome Based Commissioning Reviews" that the Council is moving to and any specific changes in funding from the Government for the area.

The new NHS Long Term Plan shows a clear intention to move towards making all NHS organisations and systems financially sustainable within 5 years. This is supported by a clear national intention that local systems move to a more transparent and collaborative approach to planning and delivery, to reduce costs but also to maintain and improve services.
In Sutton there is now a clear shift towards collaborative working, both within the health sector and with Local Authority and other partners in terms of planning and providing services in an integrated way that is focused around the person. Within the wider South West London footprint, Sutton is a Health and Care 'system', and this Health and Care Plan reflects the joined-up system approach.

Effective reduction of costs whilst providing quality services is possible, and as such system leaders in Sutton are determined to restore and maintain financial balance to support and enable this ambitious Health and Care Plan. Currently the risk in the health system to meet the 2019/20 financial targets is assessed to be at around £16m, which is a significant risk for Sutton.

We will continue to work to reduce this risk to financial targets, including working to a joint financial recovery plan to get to financial balance over two years through a joint recovery programme that works to the following principles:

- all projects are aligned with the overall objectives of the Joint Financial Recovery Board
- the scope of each programme and associated impact is led by a Senior Responsible Officer
- all programmes build on existing work
- programmes adhere to a two-year plan to deliver financial recovery

Delivery of the Joint Financial Recovery Plan will be overseen by the Joint Financial Recovery Board who will provide detailed scrutiny, support and challenge of quality, innovation, productivity and prevention (QIPP) and Trust cost improvement plans that require system support for delivery. This will ensure that there is strategic leadership oversight from the initiation of plans (e.g. approval of business cases and resources needed to deliver) through to delivery (e.g. providing leadership for contingency and mitigation plans, ensuring that lessons learned are shared and applied).

The Joint Financial Recovery Board will be supported by a Joint Programme Management Office who will provide the necessary programme and project management required to ensure successful delivery. Having this joint function will enable us to work more effectively as a system by for example:

- streamlining our structures, processes and documentation
- providing effective joint management information, challenge, reporting, governance and assurance

- leading in the joint identification and planning of benefits
- ensuring that programmes are being developed in line with agreed development principles

As part of phase one of our recovery programme we have identified seven programmes of work that we will progress to support achievement of our recovery plan, as they will either directly contribute to savings or will be key enablers to success. These are:

- Demand management – outpatients
- Reducing follow-ups
- Reducing length of stay
- Reducing admissions
- Medicines optimisation
- Estates utilisation

In addition, there are four care delivery services that are expected to be transferred to the Sutton Health and Care Alliance to expedite achievement of Year 1 of the financial recovery plan. These are the development of an end of life care hub, continuing health care services, a review of children services, and planned care services. Due diligence will be undertaken to enable transfer to the Alliance to commence during October 2019.

7. Our roadmap for delivering the Sutton Health and Care Plan

A high-level overview of some of the key delivery milestones over the next 5 years for our plan is shown below.