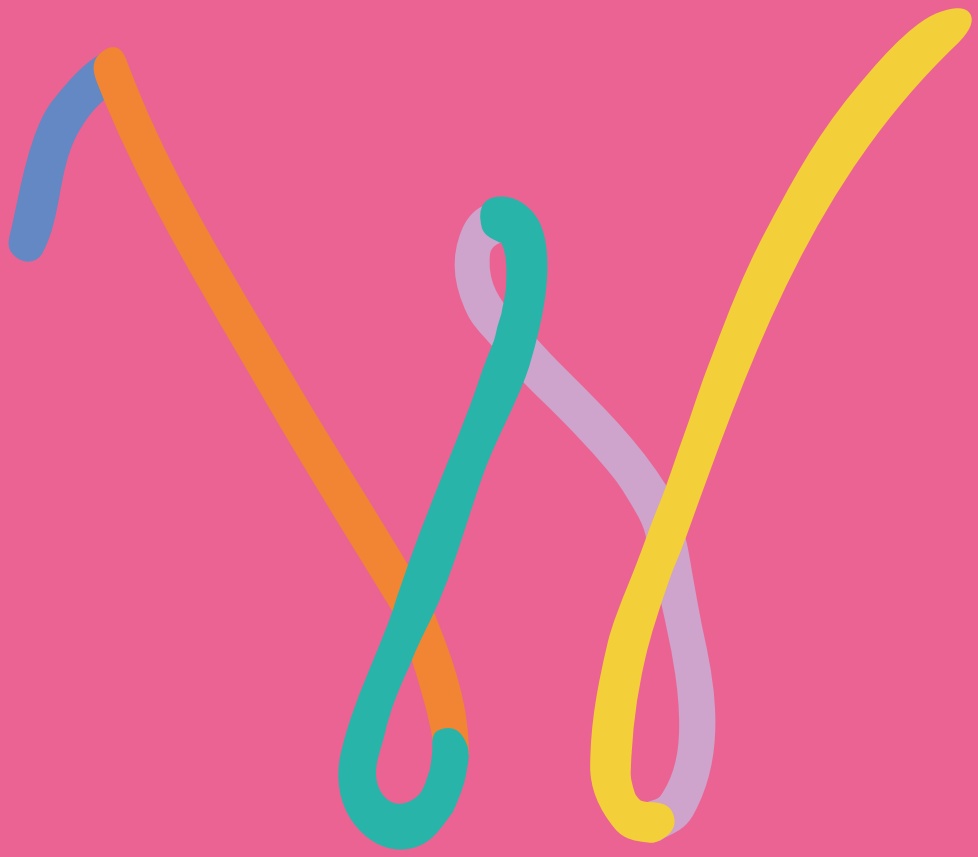
South West London Health & Care Partnership

Wandsworth HEALTH & WELLBEING BOARD

Wandsworth

Local Health & Care Plan 2019-2021



October 2019

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Wandsworth Health and Care Plan Welcome

Health and Wellbeing Board Chairman - Cllr Melanie Hampton

Wandsworth is a vibrant and thriving community and we want people to remain as healthy as they can for as long as they can. The Wandsworth Health and Care Plan has been collaboratively developed involving partners, providers, voluntary sector and residents – ensuring local voices are a direct contribution.

Our vision for the delivery of health and care fits into three themes **'Start Well, Live Well, Age Well'.** These, along with the need to join up care and embed a preventative approach covers the whole life cycle of the borough's population.

The Health and Care Plan will initially cover a two-year time frame between 2019-2021 and focus on actions which no single organisation can deliver on its own. By working together, health, social care and the voluntary sector can deliver quality health and care services that support our residents. This plan should be read in alignment with other, existing health and care strategies.

We understand the health and care needs of the borough, in part through the Wandsworth Joint Strategic Needs Assessment and as the population increases, health and care providers need to offer services in different ways to meet the growing demand.

The Wandsworth Health and Wellbeing Board will oversee the delivery of the Health and Care Plan. We will continue to work using an integrated approach with local organisations and groups to implement actions that will provide quality health and care services our residents deserve.

Cllr Melanie Hampton
Chairman, Wandsworth Health and Wellbeing Board

Introduction

Our partnership

Health and Social Care organisations across Wandsworth have been involved in shaping and developing the Wandsworth Health & Care Plan 2019-2021. 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.

As a partnership we want to ensure we have quality health and social care services that meet the needs of Wandsworth residents and will continue to do so for future generations. The additional demand on health and social care services from our growing and ageing population, the increasing number of people living with long term conditions, together with demand for new treatments and therapies are projected to outstrip growth in the budget. To meet these challenges and ensure the sustainability of our services for the future we need to rethink the way we work together to improve patient outcomes, tackle problems and make best use of all available resources.

St George's University Hospitals NHS
NHS Foundation Trust

The Brighter Borough
Wandsworth

NHS
South West London and
St George's Mental Health
NHS Trust

NHS
Wandsworth
Clinical Commissioning Group

NHS
Central London
Community Healthcare
NHS Trust

healthwatch
Wandsworth

Wandsworth
Voluntary Sector
Co-ordination Project

BATTERSEA
HEALTHCARE
Your good health locally

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 vision for health and care in Wandsworth

Start Well, Live Well, Age Well

The priorities within our plan run throughout the life course

Start Well – Childhood Obesity, Children's and Young People's Mental Health, Risky Behaviours, Children and Young People Who Need Additional Support

Mental health and ending knife crime were voted as the top issues of concern by young people in Wandsworth through Make Your Mark, a national campaign that gives young people a voice. We know that empowering children and young people, helping them build their resilience and protecting them from exploitation will support them to thrive and reach their potential. We want children to have a healthy start in life so that they can grow to be healthy adults achieving their full potential. We are concerned about risky behaviours, obesity and mental wellbeing in young people.

Live Well – Integration of physical and mental health approaches and chronic disease management- Diabetes

We know that there is no 'sound' physical health without health mental health and integrating our approach to physical and mental health is an important Live Well priority. We want people with long term conditions to be able to help themselves and Diabetes is a specific concern in Wandsworth we want to explore.

Age Well – Health and Social Care Integration, Dementia and Isolation

We want to join up health and social care services to provide a better service to residents. Increased awareness amongst front line staff has led to earlier diagnosis of dementia and helps us to look at how we can best support people living with dementia and those caring for someone with dementia. We are also looking at social isolation amongst older people; this is not a medical problem but we know this can adversely impact all areas of their lives.

Our Vision

We want people to remain as healthy as they can for as long as they can.

We are focused on prevention and joining up care where it is appropriate to deliver a better service and supporting and developing resilience in individuals and local communities.

Health and Care in Wandsworth Plan - in context

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.

Wandsworth has a large number of working age adults and a population that is more affluent than the population in general. However, Wandsworth also has pockets of deprivation throughout the borough and there are inequalities with small populations at either end of the age spectrum who are deprived and have significant health issues.

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.

43% of the borough's schools are rated as outstanding, double the proportion nationally, our examination results regularly exceed local and regional averages.

The borough has the second highest employment rate in London and there are over **18,000** active businesses in the borough, providing **134,000** jobs.

Wandsworth is the safest inner London borough, in terms of rate of notifiable crimes per head of the population. The borough also has the lowest rate of violence involving knife crime amongst the inner London boroughs.

Health and Care in Wandsworth Plan in context

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. Other elements include:

Wandsworth Joint Health and Wellbeing Strategy

Led by London Borough of Wandsworth

Sets out three key priorities: healthy places, targeted interventions and mental health alongside an overarching principle of Needs Based Commissioning.

NHS Long Term Plan

Lays out a set of expectations for the NHS over the next 5-10 years.

SWL Health and Care Partnership

Partnership of health and care providers in the six South West London boroughs

Enables commissioning and transformation of services such as cancer commissioning where this is best delivered across more than one borough.

SWL Primary Care Strategy for 2019 and beyond

Jointly owned by Croydon, Kingston, Merton Richmond, Sutton and Wandsworth CCGs.

Sets out the strategy for Primary and Community-Level commissioning in the South West London Area for 2019 and beyond.

St George's Hospital Strategy - 2019-2024

Sets out the vision to provide outstanding care every time and the priorities that will drive and influence decisions over the next five years.

Our challenges locally

The Joint Strategic Needs Assessment

The Needs

Place

10 Wandsworth **primary schools** in areas that **exceed** the legal air pollution limits

Housing estates cover 10% of the area of the borough and social housing accounts for **19%** of property

Almost a **third 32%** of residents rent privately which is higher than the inner London average **29%**

It is estimated that over **40,000 residents are exposed to high levels of transport noise** which equates to higher proportions than the London and England averages.

10th highest housing affordability ratio in the country – difficult for first-time buyers to get on the property ladder.

Start well

10,385 children in low income families

A significantly lower percentage of children have received their first dose of **MMR immunisation** by the age of two compare to England

One in four children aged 5 have one or more **decayed, filled or missing teeth**

14% the percentage point gap in attaining a **good level of development** at the end of reception for children with free school meals, which widens to **24%** by **key stage 2**

One in three children leaving primary school aged 10-11 years are **overweight or obese**

12% of 15 year-olds partake in 3 or more **risky behaviours**

5% of 15 year-olds are **regular smokers** fifth highest rate in London

15% of 15 years-olds report having **tried cannabis** significantly higher than the London and England averages of 11%

The Needs

Live well

37,000 adults are estimated to smoke

44% of adults drink more than the recommended limit of **14 units of alcohol per week**

4,950 new **STI diagnoses** (excluding chlamydia aged < 25)

Over **19,000 carers**

15,000 residents living with **diabetes** and another **25,000** are on the verge of **developing it**

44,000 people estimated to have a common mental health disorder, such as **depression and anxiety**

More than half of over 16's are **overweight or obese**

The rate of **family homelessness** has increased from **4.7 to 6.3 per 1,000 households** in 2015/16

Age well

29,300 to 42,200 the projected increase in number of over 65-year-olds between 2015 and 2035 (44%).

Life expectancy at age 65 for both males and females in Wandsworth is significantly **lower than the London average**

Average person can **expect 15 years** of **deteriorating health** in old age

1,387 patients with **dementia** recorded in registers

One in five older people are on **low incomes**

10,000 people aged over 65 **live alone**

1 in 4 victims of recorded **fraud** are aged **65 and over**

Almost **800 hospital admissions** due to **falls** per year

9,000 over 50's are **unpaid carers**

3,420 people aged 65 and over are estimated to be living with **visual impairment**

Key local issues:

Emotional Wellbeing and Mental Health, Risky Behaviours, Overweight and Obesity, Long Term Conditions and supporting wellbeing and independence

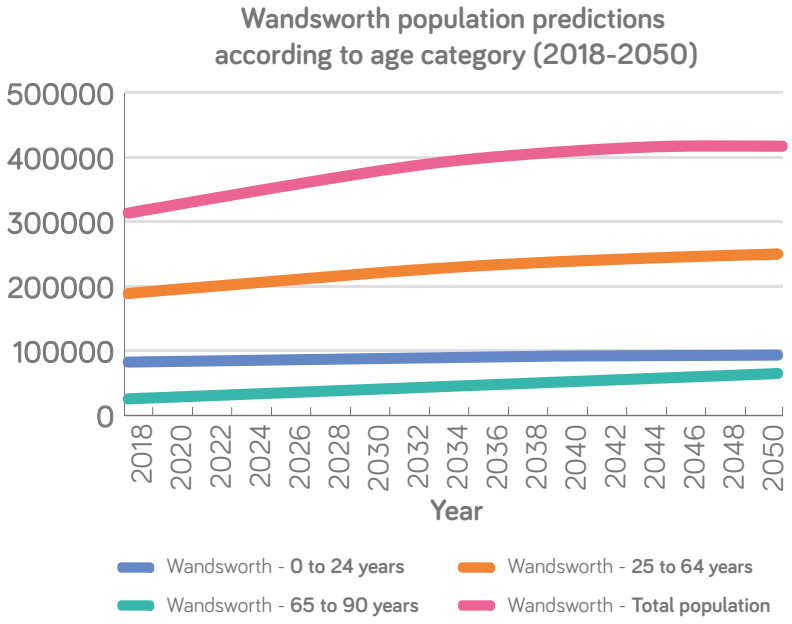
Our challenges locally

Population growth and rising demand

Wandsworth is the largest inner London Borough. It has a population much younger than both the London and England average.

Nearly half of residents are aged between 25-44 years.

Wandsworth has the highest proportion of people **aged 30-34 years nationally;** creating a unique young, diverse population.



Wandsworth has a growing population with the number of older people set to grow faster than the overall population.

There are issues with rising demand, with the greatest demand concentrated in care of the elderly and those with complex care needs.

4 in 5 people aged over 65 have at least one chronic illness.

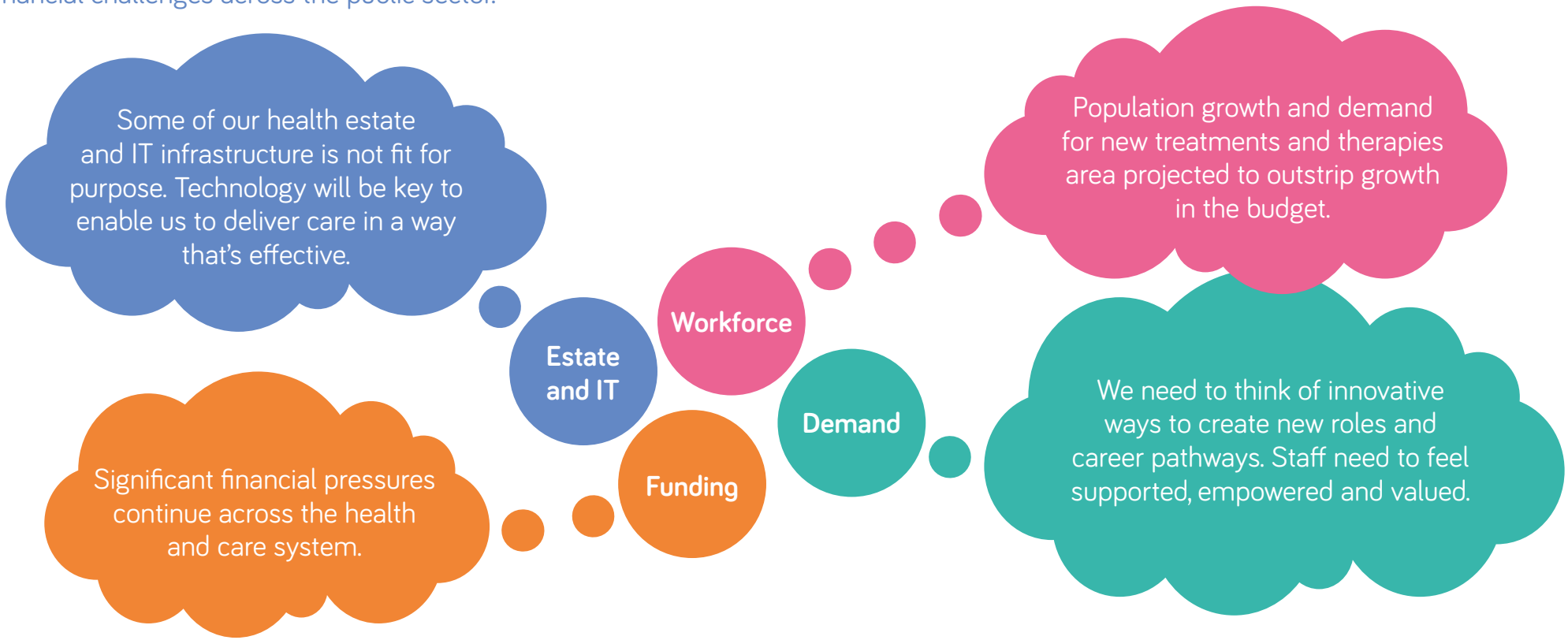
Dementia mainly affects older people and after the age of 65, the likelihood of developing dementia roughly doubles **every five years.**

- People are living longer with long term conditions.
- Patient expectations are changing; people are applying the same principles of instant gratification to health and care services.
- We have workforce shortages in nursing and general practice.
- Funding is causing financial challenges as is the cost of provision.
- Health Services have some estates and IT systems which aren't really fit for purpose.
- High needs in specific services (sexual health, drugs & alcohol).

Our local challenge

Quality, performance and financial context

There are a number of challenges to the quality and performance of our health and care services, set against the context of significant financial challenges across the public sector.



Therefore partners must work together to redesign services and improve efficiency within our existing resources to ensure a sustainable health and care system for future generations.

Our local challenges

Workforce

Our workforce is our greatest asset and at its best is able to deliver world class exemplary care. The current financial challenges are paralleled by shortages of clinicians and other health and social care staff in most areas of the system who commonly describe 'fishing from the same pond' as they compete for staff.

We will work together with our partners to ensure the health and wellbeing of our staff and to:

- Uphold a learning culture and 'grow your own' approach that supports newly qualified staff to flourish.
- Support the resilience of the workforce via regular high-quality professional supervision and reflective learning opportunities.
- Encourage the continuing professional development of staff via a varied and flexible training programme and regional teaching partnership.
- Care for our staff supporting their health and wellbeing.
- Make the best use of our resources: collaborating where it is right to do so.
- Recognise the work and commitment of our staff through reward and recognition programmes that mirror best practice.
- Involve our staff in what we do - engaging our staff, who know our services and patients best, to help us transform and improve the way we work.

Our local challenges

Ensuring a sustainable market

As the needs of our residents change and increase, the social care market and workforce needs to adapt. One of our biggest challenges to ensuring quality and market stability is having a sustainable workforce.

National information provided by Skills for Care forecasts show that if the adult social care workforce grows proportionally to the projected number of people aged **65 and over** in the population between 2017 and 2035, an increase of **40%** (650,000 jobs) would be required by 2035 and many of these roles will be as paid carers.

In Wandsworth there was an estimated turnover rate for social care staff of **38%** which is higher than the regional **(24%)** and national **(28%)** average.

In Wandsworth certain type of home care packages have been particularly difficult to source, this includes support to people with complex support needs. The demand for this has increased as we have moved towards supporting increasing numbers of people with high and complex support needs to remain in their own home.

What local people have told us

- People with long term conditions want more guidance and support in managing their condition.
- People want their GP practices to offer more services - so they do not have to go to the hospital.
- Better identification of and support for carers.
- Mental Health access - there are long waiting times to be seen. Generally, people are happy to go to locations closer to home.
- People want better support after discharge from a hospital setting.
- Children's mental health - more support to ensure young people are able to speak up about their mental health.
- Accessibility - services are very good however, it takes a long time to access them.
- Services can seem disjointed, all services need to work better together to support families.
- Open to the idea of new technology in supporting enhanced health and social care. Some options, such as telephone advice lines, mobile phone apps, were more popular than others.
- Supportive of social prescribing and other innovations.

"Patients experience care from many different heath and social care professionals, frustration with fragmentation and duplication –concern that some services seem disjointed.

"Mental Health access -long waiting times and location. Most people said they were most comfortable going to informal places to access mental health support rather than hospitals/clinics.

"People are keen to improve their own health, particularly in areas such as losing weight and taking more exercise. Many wanted more support from health professionals to help them make changes in their lifestyles.

"Children's mental health-most common theme was how we can ensure that children are comfortable saying when they need mental health support.

"Support after discharge from a hospital setting -the need to bring health and social care closer together, services need to be more joined up so that the right care is given to the individuals.

"Services can sometimes seem disjointed, when your care is more complex and there are different agencies involved it is really important to people that health and care professionals are talking to each other and that care is focused around you.

What local people have told us

Health & Care Partnership Event

We held a health and care partnership event on 21st November 2018 to seek feedback from front line staff, residents and wider stakeholders on the areas of focus within the Wandsworth Health and Care Plan.

We used the information gathered through the work of Wandsworth's Youth Council and Participation People to build on this and support us in developing our Start Well priorities.

Our work

Wandsworth Local Health and Care Plan 2019 -2021

The priorities within the Wandsworth Health & Care Plan are focused on the areas where we can have the greatest impact by working collectively to tackle the causes of health and wellbeing issues. Whilst these priorities have been developed under the themes of Start Well, Live Well, Age Well many of the priorities and actions we have identified will impact across the **whole** life course.

Our work

Cross cutting themes

Whilst we have identified priorities within Start Well, Live Well, Age Well there are a number of issues which require a cross cutting thematic approach as they impact on health and wellbeing throughout life. Examples are:

- Economic factors and housing stability both of which inter-relate with health inequalities.
- Carers –unpaid carers and young carers are important groups which cut across the Start Well, Live Well, Age Well themes, who require support.
- The preparation for adulthood and the transition from child to adult services covering the 16-25 age range which cuts across the Start Well, Live Well themes.

A key overarching principle is evidence-based initiatives across the system

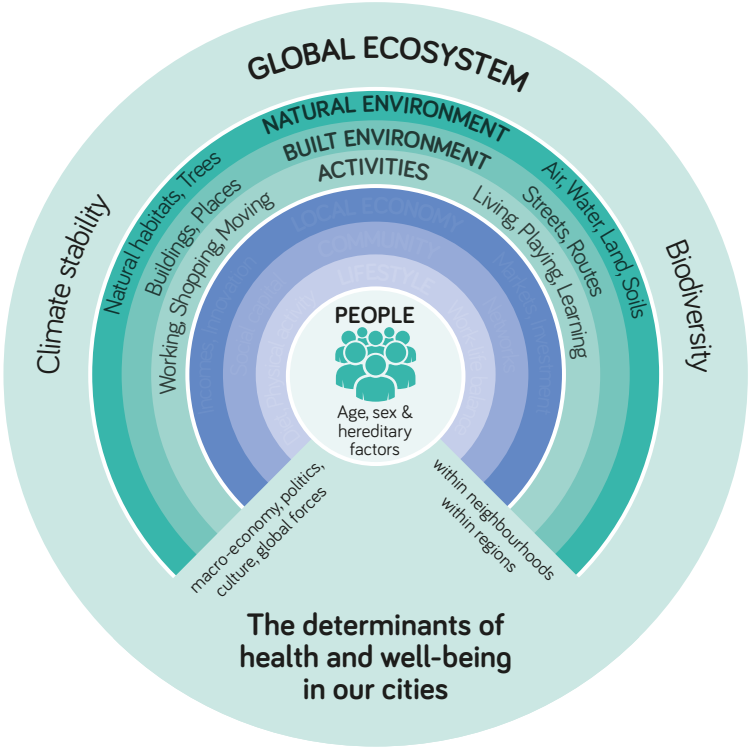
Our work

Focus on prevention

'Prevention' is a key cornerstone of our approach across health and social care. Prevention is better than cure, so it's important to focus on doing things well early on.

Health is affected by our make up, lifestyle and environment. The health map produced by World Health Organisation and University of Bristol helps us to understand what effects our health.

Only 10% of our health is affected by healthcare.



What makes us healthy?

As little as **10%** of a population's health and wellbeing is linked to access to health care.

We need to look at the bigger picture:

But the picture isn't the same for everyone.

The healthy life expectancy gap between the most and least deprived areas in the UK is **19 years**

Our work

Defining prevention

National Policy Context

The 2014 Care Act and NHS Five Year Forward View both emphasised the importance of a shift towards a preventative approach that promotes wellbeing and maintains independence to ensure the future sustainability of the health and social care system.

Primary prevention aims to promote population health and wellbeing, prevent disease and harm before it occurs –i.e. for cardiovascular disease primary prevention would be addressing risk factors through smoking cessation, physical activity.

Secondary prevention aims to reduce the impact of a disease that has already occurred or preventing a recurrence. i.e for cardiovascular disease by taking a statin or aspirin secondary prevention after a heart attack or a stroke we are trying to prevent another one.

Tertiary prevention treats disease with cost-effective interventions to slow or reverse disease progression. It includes rehabilitation for disability (seen as a "downstream approach"). i.e. in diabetes, preventing amputation by good foot care.

Implementation of the Prevention Framework

Delivery of the Local Health and Care Plan -scaling up four prevention interventions:

1. Supporting healthy workplaces by encouraging local employers to become accredited with the London Healthy Workplace Charter.
2. Reviewing and embedding Making Every Contact Count (MECC) training across all frontline staff.
3. Scaling up the Social Prescribing programme.
4. Embedding public health initiatives in procurements/care pathways, using a prevention matrix.

Local Policy Context

Wandsworth's Joint Strategic Prevention Framework outlines preventative interventions should focus on:

- Making the health and wellbeing of our communities everyone's responsibility.
- Creating environments where the healthier choice is the easier choice every time.
- Harnessing local communities and their assets to build resilience amongst people and their carers.
- Embedding self-care and promoting a recovery model.
- Promoting prevention and independence across all health and social care pathways.

The agreed approach is centred on implementation across the life-course and across three levels;

- Place and policy level solutions e.g. environment and planning, legislation and regulation;
- Community level solutions e.g. volunteering, connectivity, community cohesion; and
- Individual level solutions e.g. intensive services for vulnerable individuals in most need and online 'E-solutions' to offer a less intensive, cost-effective approach to the community more broadly.

Start Well

Children and young people are the future. We want all children, young people and families regardless of their background, circumstances or start in life to feel they belong in Wandsworth and have the support they need to thrive and achieve their potential.

For some children, life can be more challenging and their circumstances and family background have an impact on how well they achieve, how healthy they are, how secure they feel and how safe they are. We want to make a sustained difference to these children and in addition to continue to do the best for all children so none get left behind.

Together we can make Wandsworth a place where children, young people and families thrive. We'll do this by orientating our Start Well implementation plan around the six components of THRIVE Wandsworth which we agreed as our strategic approach to early help in February 2018.

We have three Start Well themes that reflect the things we want to focus on:

Mental Health | **Risky Behaviours** | **Childhood Obesity**

Children looked after, children known to children's social care and children with SEND and complex needs

To this, we are also adding our commitment to ensuring good experiences for children looked after, children known to children's social care and children with special educational needs and disabilities (SEND) and complex needs.

Our work - Start Well

Responding to messages from the Wandsworth Health and Care Partnership Event and from children, young people and families

A Start Well Charter for Wandsworth

As a partnership, we are committed to ensuring we develop our plans based on the messages from the community about what matters. So in response to the feedback from the Health and Care Partnership Event and other engagement activities we have developed our Start Well Charter.

Together, with children, young people and families we will turn our charter into a Place Based Implementation Plan. This will set out what we are going to do to make Wandsworth an inclusive borough, where children young people and families feel they belong, are supported to reach their potential, have emotional and physical well being, are resilient and make positive choices. It is our aspiration that all Wandsworth children have their needs met in Wandsworth.

Wandsworth's Start Well Charter

- We all think family.
- We listen to children and young people and give them opportunities to shape the way we work.
- We work collaboratively.
- We make accessing help and information easy for children, young people, families, communities and professionals.
- We deliver and commission services in partnership with each other.
- We promote healthy choices.
- We invest in support for new families and parents, from birth or before, support for children and young people through transitions and support for adolescents to become adults who thrive, even when this means we need to work beyond 19.

Our work - Start Well

Priorities to deliver our Start Well themes

Our work - 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.

The prevalence of diabetes in Wandsworth is driven by demographics and related to lifestyle choices. The subsequent impact of poor health and mental wellbeing results in huge costs to the individual, the economy and the health and social care system.

Our work - Live Well

Integrating Physical and Mental Health Approaches

An estimated **44,000** people aged between **16** and **74** have a common mental health disorder such as depression and anxiety.

A survey of local people indicates that **44%** of adults drink more than the recommended **14** units of alcohol per week; the highest proportion in London.

An estimated **3,743** adults are alcohol dependent with the highest rate in men aged between **25** and **34**.

The link between **mental wellbeing and physical health** has been well documented; the ability to manage chronic conditions can be impaired in those suffering from mental health issues.

The life expectancy of people with severe mental illness is reduced, on average by **15-20** years mainly due to preventable physical illness.

What we will do:

- Physical Health Checks for people with serious mental health.
- Talking Therapies (IAPT) – increase access to psychological therapies.
- IAPT Long Term Conditions Pathway providing support to people with Diabetes, Chronic Obstructive Pulmonary Disease and cardiovascular conditions.
- CAHS Home Based Support – proposal for a mental health support worker to work alongside community staff to identify patients with long term conditions that could benefit from support with mental health needs.

Our work - Live Well

Chronic Disease Management – Diabetes

4.2% of the population over 17 years are registered with diabetes against expected prevalence of **6%**.

An estimated **9.0%** of people in Wandsworth are at increased risk of developing diabetes and every week **15** people are told they have diabetes.

South Asian and black communities are **two to four times more likely** to develop Type 2 diabetes.

Diabetics are more likely suffer from poor eyesight, kidney problems, knee problems and amputations.

Prevalence is driven by demographics and related to **lifestyle choices**.

80% of cases of type 2 diabetes can be delayed or prevented by making simple lifestyle changes.

What we will do:

Implement new models of care to:

- Support for consistent care for diabetic and pre-diabetic patients across primary care.
- Enable consultant deep-dives within primary care.
- Provide additional clinical capacity in community settings to enable more patients to be supported closer to home.

Education programmes:

- Increase attendance at structured education programmes to improve patient confidence to self manage.
- Provide extra capacity at evening and weekends to improve uptake.

Our work - Age Well

Many older people in Wandsworth enjoy active, healthy lives and have limited contact with health and social care services.

It is important that everyone has access to advice and information they need to keep them well, helping them to look after their own physical and mental health. This will include access to "Social Prescribing" from GP practices and other preventative services. Although life expectancy continues to increase incrementally, healthy life expectancy is much shorter than overall life expectancy and the average person in Wandsworth can expect 15 years of deteriorating health in old age.

For older people with the greatest health and social care needs in the borough, this plan outlines what we will be doing to improve services.

How are we currently doing?

It is important for residents the health and social care services they use perform well. One of our successes in Wandsworth is how we perform against national targets set through the Better Care Fund. These targets set out to measure the success of health and social care integration in the borough.

Unplanned admissions to hospital

We are performing well in reducing unplanned admissions to acute hospitals. This shows that we have good primary care and community services that can respond when people becoming unwell at home.

Permanent admissions in care homes

There has been a reduction in older people moving into residential and nursing care homes. This shows we have good health and social care support in the community to keep people living in their own homes for longer.

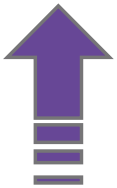
Supporting people home from hospital

We have some of the best performance nationally in supporting people home from hospital, with low numbers of people who are "delayed" in hospital while waiting for community health or social care services. This shows that we have responsive services and we work well across health and social care services to plan someone's discharge from hospital.

Our work - Age Well

Joined Up Health & Social Care

44% The projected increase of people aged 65 or over in the next 20 years.



The accumulated impact of behaviours and exposures earlier in life, combined with functional decline leads to **increased levels of disease** in older people.

The rate of hospital admissions for injuries due to falls in those aged **65 and over** is significantly higher than the national and regional averages.

In Wandsworth, **9,000** people aged 50 years and older are unpaid carers.

What we will do:

- Improve access to intermediate care and reablement services, with better coordination between services.
- More coordination of community services for people with the most complex health and social care needs, including support for their carers.
- Improve falls prevention services including an enhanced community exercise programme with access to evidenced based training.
- Improve health care support to the very frail, including residents in care homes.
- Map existing health and social care services for frail, older people in the borough.

Our work - Age Well

Dementia

The number of patients with a **diagnosis of dementia** recorded on GP registers is growing with greater awareness amongst front line staff.

This timely diagnosis helps with planning care and support leading to better quality of life for the patient and their family.

Dementia mainly affects older people and after the age of **65** the likelihood of developing dementia roughly doubles **every five years**. With the number of older people in Wandsworth set to grow faster than the overall population and as people live for longer, dementia presents us with a growing challenge.

There are almost **two women to every man** with dementia.

What we will do:

- Improve Care Navigation and planning, integrating dementia care into other care planning streams so that more people are able to maintain independent living in their own home or place of care.
- Improve support to unpaid carers of people with dementia, with aligned pathways for unpaid carers for people having specialist mental health dementia services and more proactive engagement with carers.

Our work - Age Well

Isolation

Isolation is an issue that can impact on physical and mental wellbeing across the age spectrum. **Isolation in older age** is an important focus as it is a preventable cause of both physical and mental health problems.

Over **10,000** older people live alone and over 20% of older people are on low incomes. Isolation in older age often disproportionately affects people living in more deprived areas or who are on low incomes.

Social isolation is also a factor in **increased alcohol use**. Nationally there has been a marked increase in alcohol related hospital admissions for older people. Isolation is known to increase health service demand.

Isolation in older age is an important focus as it is a preventable cause of both **physical and mental health problems**, including depression, dementia and cardiovascular disease.

What we will do:

- Improve the preventative services offer provided by the voluntary sector with a focus on intergenerational activities.
- Improve the coordination of services through the commissioning of an enhanced Voluntary Sector Coordination programme.
- To support our digital Social Prescribing offer (the Wandsworth Wellbeing Hub), we will be aiming to launch our face to face Social Prescribing service in Wandsworth by September 2019.

Our work - Quality Benefits

Quality Benefits

Quality improvement benefits which will be delivered by the initiatives outlined within the Health & Care Plan are common across the Start Well, Live Well, Age Well themes.

These will be delivered through the focus on:

Prevention

Maintaining good health, independence and promoting wellbeing.

Resilience

Promoting self care and halting or slowing progression of disease, together with interventions to improve the existing condition.

Joining up care

Resulting in patients being able to access services quickly and efficiently in a community setting where their needs are fully understood.

Creating the right environment

Key Enablers

Embracing transformation and partnership working

Increasing demand on parts of the health and care system and tighter finances will need to be managed by working in partnership to transform the way services are delivered.

Increased focus on prevention

By its very nature prevention is not a clinical intervention and is delivered most successfully in convenient local environments that people are familiar and comfortable with, such as those provided by community and voluntary organisations.

Supporting unpaid carers

We recognise their input is really important.

Making better use of our estate

And the green spaces in the Borough to promote health and wellbeing.

Drawing on the skills and expertise of the voluntary and community sector

Recognising the potential within the voluntary sector to play an active part in addressing the health and wellbeing challenges we face.

Social Prescribing

Working with emerging Primary Care Networks to ensure positive learning from existing social prescribing models is built upon to deliver the best outcomes.

Creating the right environment

The Voluntary and Community Sector

The voluntary and community sectors present us with some of the greatest untapped potential resource to meet local health and wellbeing challenges, as part of joined up health and care system, through prevention and coproduction.

We recognise voluntary and community sector organisations:

- Play an increasingly important role in the Health and Care Plan.
- Understand local needs and local solutions. They can engage with communities which statutory organisations struggle to reach.
- Have a growing appetite to work collaboratively not only with each other but with our commissioning bodies and providers.
- Can provide added value through local knowledge and intelligence, involving volunteers, attracting additional external funding and utilising local venues.

We recognise that statutory and voluntary/community sector stakeholders have a shared responsibility to ensure our social care, community, wellbeing and hospital services are as joined up as possible so we can collectively tackle the causes of health and wellb.eing issues.

Investment in infrastructure to support the development of the voluntary and community sector potential is already underway.

Creating the right environment

The Voluntary and Community Sector in Wandsworth

The voluntary and community sector in Wandsworth consists of several hundred voluntary groups and organisations, including charities, condition support groups, and faith groups. Many of these organisations are small and informal. Whilst there is no comprehensive list of all the organisations within Wandsworth, the Charity Commission lists 565 registered charitable organisations in the borough.

A "Thinking Group" of local voluntary organisations has been established. This group meets to consider and address local challenges and opportunities. Alongside the "Thinking Group", the Wandsworth Voluntary Sector Coordination Project (VSCP) has been responsible for developing the well-attended Voluntary Sector Forum.

Wandsworth CCG and Wandsworth Council are seeking to build on the success of the existing VSCP to enhance voluntary sector capacity and achieve their shared vision of a sustainable and vibrant voluntary and community sector.

Through procurement, Wandsworth CCG and Wandsworth Council are seeking to appoint an enhanced support service, which will act as a liaison between the voluntary sector, the CCG and Council, to build capacity and connections with local organisations and help deliver more broadly on local health priorities.

Creating the right environment

Social Prescribing in Wandsworth

- Social Prescribing is a means of enabling clinicians to refer people to a range of local, non-clinical services to improve their health and wellbeing. Recognising that people's health is determined by a range of social, economic and environmental factors. Social Prescribing seeks to address people's needs in a holistic way by facilitating access to the right support, in the right place, at the right time.
- The new GP Primary Care Network contracts provide new funding for Social Prescribing Link Workers to be employed by each Primary Care Network. Clients referred to the Link Workers will receive 1:1 support through a series of consultations, including connecting them to other agencies in the community, which can help to address their needs.
- The CCG is working with emerging Primary Care Networks to ensure that positive learning from existing Social Prescribing models is built upon to deliver the best outcomes.
- This will include supplementing the funding allocated through the GP Primary Care Network Contract to ensure an effective and sustainable Social Prescribing model is delivered across the Borough.
- Through our early help strategy, THRIVE Wandsworth we are creating new ways to connect children, young people and families to non-clinical services through our early help pathway.
- We have established a community led fund and are developing Wandsworth Giving to allow communities to give and receive more early help.
- We are placing early help practitioners in the community and schools.

Recognising partnership working with the Community and Voluntary Sector is key to this, the CCG will also work jointly with the sector and other stakeholders, building capacity and resilience to manage the increased pressures which Social Prescribing may bring.

Other work

Primary Care in Wandsworth

Challenges

Increased demand and complexity of care, workforce shortages as well as changing national policy means we must transform how Primary Care is delivered.

- The Primary Care workforce has changed with a shift towards more GPs working part time and in a salaried or locum capacity. This can cause gaps in frontline clinical time for consultations but also in a reduction in leadership capacity within practices.
- National policy demands the provision of Primary Care 8am-8pm 365 days a year.
- There is an increasing number of elderly and more complex patients needing care in the community.
- There are differences in the quality of services between different GP practices in Wandsworth.
- There are significant health inequalities within the borough.
- The existing infrastructure (IT & estates) are not always fit for purpose to deliver high quality care.

Wandsworth has a GP registered population of 410,000

Other work - Primary Care in Wandsworth

What we are doing to improve services

On 31st January 2019 NHS England and the British Medical Association (BMA) General Practitioners Committee in England published a five-year framework for GP Contract Reform to implement the NHS Long Term Plan. The new GP contract sees practices increasingly working together in networks to improve resilience and sustainability, increase capacity and provide local population based care which is integrated with wider system partners.

Primary Care Networks (PCN)

These will be the cornerstone to transforming general practice, supported by contractual changes which will support Primary Care transformation.

Primary care at scale (PCAS)

We will build on the progress made through pilots in 18/19, so Primary Care at Scale becomes a core part of how general practice operates. This will include consideration of more efficient ways of working such as:

- Maintaining and scaling up back office functions in practices
- Investigating how efficiencies of scale could be achieved and also utilisation of collective purchasing power

Workforce -we will work to support our workforce by:

Working with Networks and Federations on workforce plans aligned to PCAS & PCNs, focussing on enhancing skill mix, using the workforce in new and innovative ways and using community services staff appropriately.

Access - we will continue to improve access by:

- Continuing to develop our extended access model to enable direct booking from NHS 111 and A&E
- Embracing opportunities from technology and innovation where it makes sense to do so
- Joining up urgent care systems with primary care so that patients are seen in the most appropriate place to meet their needs.
- Improving public education in relation to self-care

What will be the impact?

- High quality, sustainable accessible Primary Care which is pro-active, co-ordinated and delivered across the Borough.
- Direct booking of appointments from NHS111 and A&E into all GP practices.
- All patients will have access to digital first primary care, including web and video consultations, online booking of appointments and electronic repeat prescriptions.
- All patients have access to social prescribing services.
- Patient care is holistic and joined up across multiple agencies

Other work - Primary Care Networks in Wandsworth

Primary Care Networks

- The new five year framework for GP Contract Reform introduces a new Primary Care Network (PCN) Contract which requires practices to come together in geographical networks covering populations of approximately 30,000 - 50,000 patients to share some staff and services. The CCG and the GP Federation (Battersea Healthcare Community Interest Company) are supporting practices to develop network arrangements and to ensure 100% coverage of networks across the Borough by the 1st July 2019 (which is the national deadline). Currently we anticipate that there will be 9 networks that are broadly geographically aligned.
- Over the next 1-3 years, additional funding for specific Primary Care roles (clinical pharmacists, social prescribing link workers, physician associates, first contact physiotherapists and first contact community paramedics) will be provided to networks and new specifications and models of care will be delivered.
- Once network proposals are received and approved the CCG and GP Federation will work with PCNs to support the introduction of new roles (initially Social Prescribing Link Workers and Clinical Pharmacists) in a co-ordinated way over the summer.
- The CCG also has a key role in working with other providers and stakeholders to support the alignment of community nurses, social workers and mental health workers with the new networks to provided better joined up and holistic care for local populations. Positive engagement between the CCG, Wandsworth Council and community service providers is already underway.
- Over the past 18 months practices across Wandsworth have been encouraged to consider opportunities for 'at scale' ways of working, acknowledging that this will enable practices to become more sustainable and resilient in the long term and will help them deal with challenges workforce shortages and increasing demand. The new contract provides the contractual and financial levers needed to formalise these working arrangements.

Other work

Acute Transformation

Outside of the Wandsworth Health and Care Plan partners are working to ensure the quality and sustainability of services meets our aspirations.

Acute Transformation:

Planned Care and Urgent & Emergency Care

Planned Care

- Developing Primary Care to support people outside of hospital where possible.
- Cancer: new diagnostic tests to reduce the need for invasive procedures. Psychological support for people living with and beyond cancer.
- Effective Commissioning Initiative, ensuring that procedures are evidence based.
- New community services to manage hospital demand e.g. community ophthalmology services.
- Clinical Assessment Services.
- Outpatient Transformation and Redesign - development of virtual clinics online and over the phone.
- Diagnostic pathway improvement.

Urgent and Emergency Care

- Ambulatory care - same day medical support for adults and children to avoid admissions to hospital.
- Integration of Primary Care expertise and capacity to avoid A&E attendances where possible.
- Alternative Care Pathways - working with London Ambulance Services to identify where patients can receive support quickly rather than attend A&E.
- Older Peoples' Advice and Liaison Service - providing tailored support to older people when in A&E.
- Integrated Urgent Care (NHS 111).

Other work

St George's Strategy

St George's strategy at a glance...

Delivering outstanding care, every time

Our strategy for 2019-2014

Our vision is to provide outstanding care, every time for our patients, staff and the communities we serve.
We have agreed four priorities that will drive what we do and influence the decisions we will take over the next five years.

Strong foundations

To provide outstanding care, every time

- We will provide outstanding care, every time
- We will provide the right care, in the right place, at the right time
- We will invest in our staff
- We will manage our funding and spending, and invest in our future
- We will improve our buildings and hospital estates
- We will make sure our staff and patients have access to the digital technology they need when and where they need it

Excellent local services

To provide excellent local hospital services for the people of Wandsworth and Merton

- We will provide planned care that fits around our patients' lives using the latest technology
- We will provide more same day emergency care

Closer Collaboration

To work with others to provide health services for people across south west London

- We will work with our partners to provide care closer to patients homes
- We will work with neighbouring hospitals to make sure they get the care they need
- We will work with others to meet the changing needs of age ageing population

Leading specialist healthcare

To provide specialist healthcare for the people of south west London, Surrey, Sussex and beyond

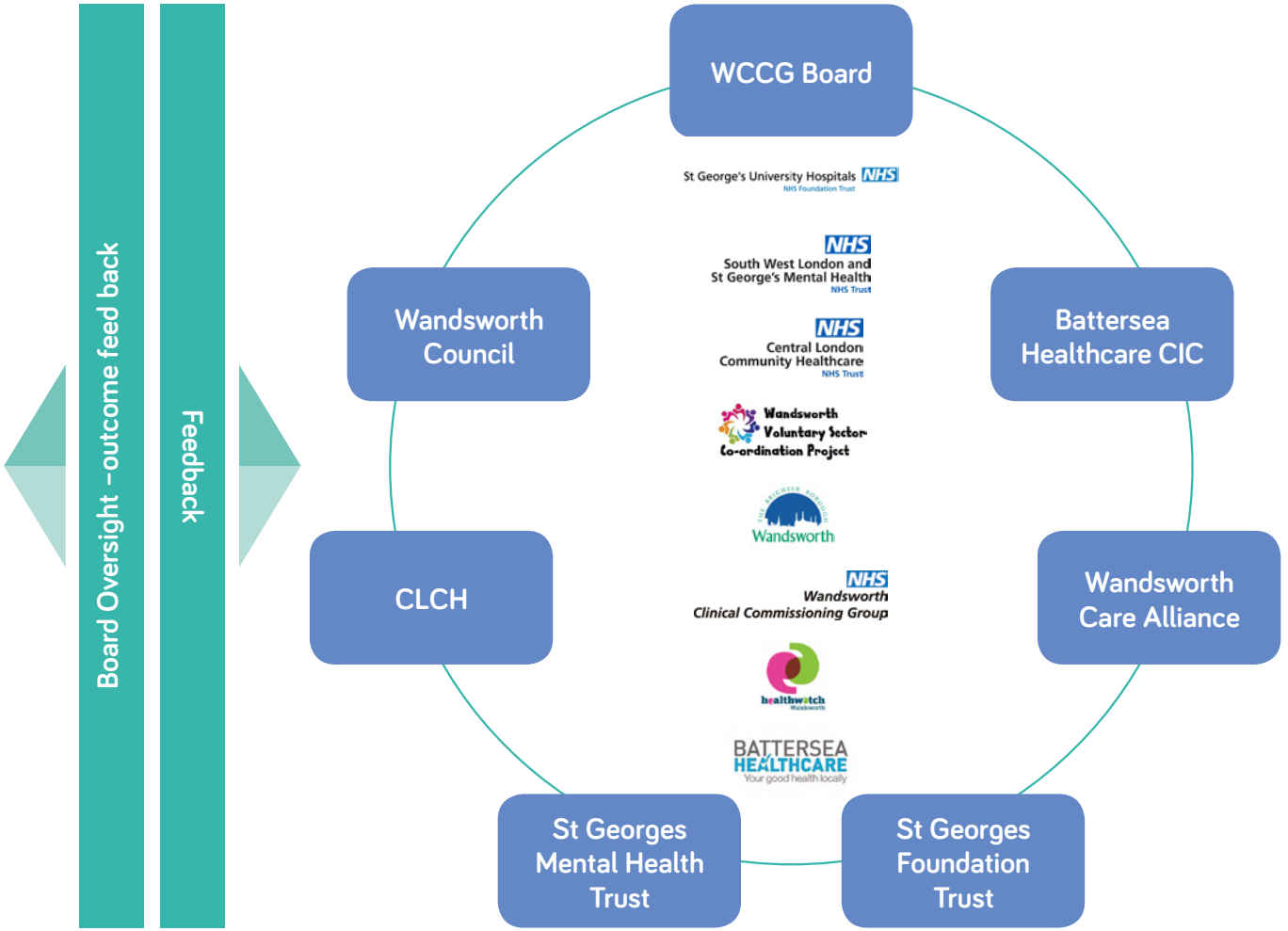
- We will continue to be the main provider of specialist services for our region, including as the major trauma centre
- We will be a major trauma centre for cancer, children's and neuroscience services
- We will take part in commercial opportunities that enable us to invest more in NHS care
- We will develop tomorrow's treatments, today, through innovation, research and training

Delivering outstanding care, every time - our strategy for 2019-2024

Delivery and Governance

The development and delivery of the Wandsworth Health and Care Plan is overseen by the Wandsworth Transformation Group, 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.

The Wandsworth Transformation Group reports into the Wandsworth Health and Wellbeing Board on a regular basis. Two way communication allows each partner organisation regular updates back to their organisations.



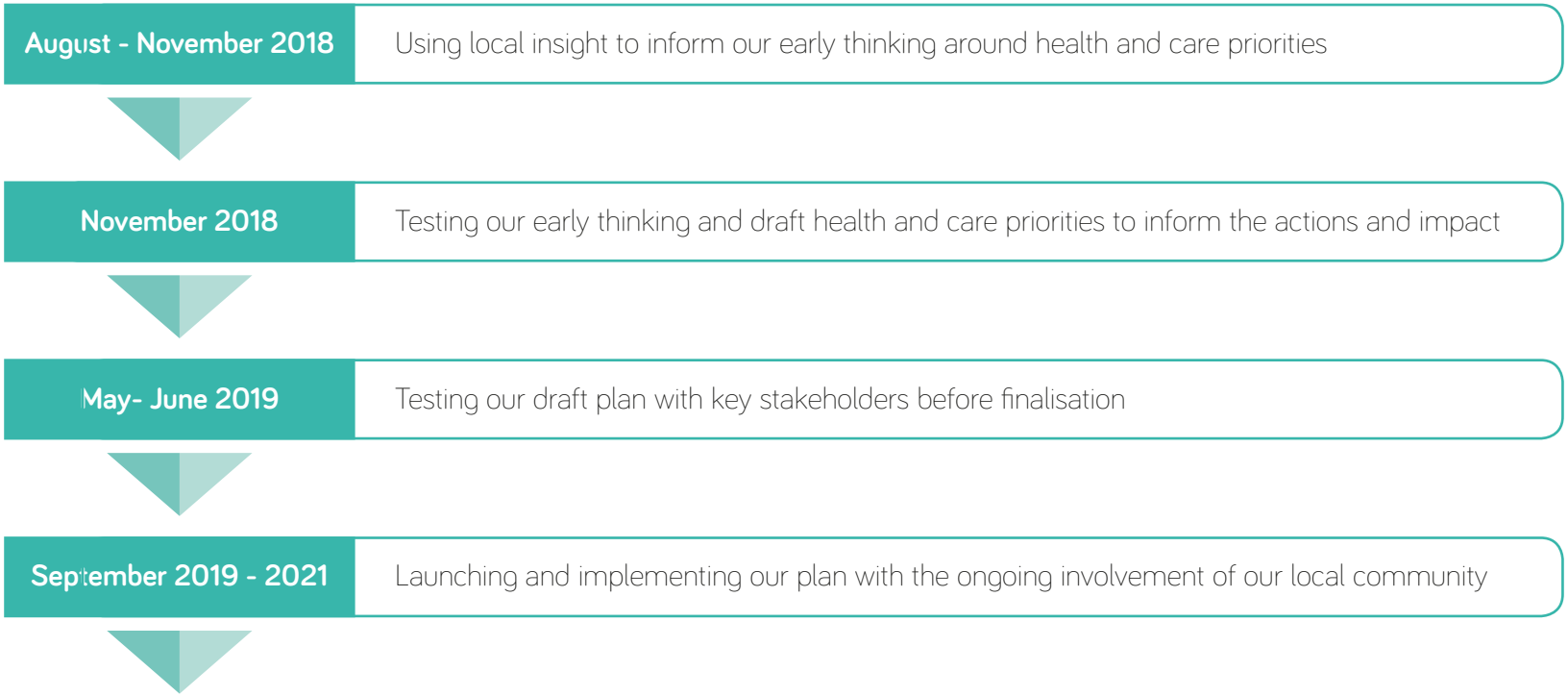
Involving local people

In developing a Local Health and Care Plan for Wandsworth

The Wandsworth Health and Care Plan describes our 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. It is a two-year (2019–2021) plan which focuses on the actions which no single organisation can achieve alone. By working together, we believe health, social care and the voluntary sector can deliver quality health and care services that support local people.

It has been essential to develop this plan with local people – a commitment of all partners. Between August 2018 and July 2019 we spoke to around 250 people to hear what they want from health and care services and to test our ideas with a cross section of local people at different stages in the development of the plan.

Our engagement process



Using local insight to inform our early thinking

Wandsworth's health and care partners considered views of local people gathered over the last year including what we learnt through our commissioning intentions engagement work undertaken in Summer/Autumn 2018. This shaped our thinking as we developed our early ideas about what health and care priorities for Wandsworth would look like. This included hearing from communities and groups who do not always feel their voice is heard or may face specific barriers to involvement, for example people who self-identify as LGBTQ+, people disabled by sensory, perceptual, physical and emotional processing difficulties (Learning Disabled), people who care for others whether paid or unpaid and BAME communities. We used feedback from local people to refine our early ideas into a set of draft priorities that were presented at our deliberative event in November 2018.

Testing our early thinking and draft priorities

In November 2018, we held an engagement event for local people, health and care staff, and representatives from community organisations. We talked about the kinds of things which no single organisation can achieve alone and how organisations could work better together. We also shared what people had already told us about what they want from local services.

Discussions focused on:

- Childhood obesity
- Children and young people's mental health
- Risky behaviours
- Integration of our approach to physical and mental health
- Diabetes
- Dementia
- Health and social care integration
- Isolation

Over 160 people attended the event– including around 50 local people who had been specifically recruited to represent the diverse community in Wandsworth and who had never worked with us before.

We worked with a specialist organisation to reach out to a representative cross section of the community using online advertising and on-street recruitment. As a result, we heard from a range of people we wouldn't ordinarily have reached including from those in deprived communities, young adults and people from multicultural backgrounds.

There was great energy and fresh ideas in the room. It was clear that people were passionate about health and care in our borough and wanted to support us. We made a video of the event which captured the feeling of the day: https://www.youtube.com/watch?v=wOldN0IWrQM

The following provides a snapshot from the day.

Testing our draft plan with key stakeholders before finalisation

We have used the ideas generated during the event, and from existing insight, to develop our Health and Care Plan, as well as considering priorities around prevention and early intervention that have been published in the NHS long-term plan, issued recently by the Government.

The plan was published as a discussion document in May 2019 to test it with our partners and those who helped shape it. We used this discussion document to continue the conversation - and start talking to people about how to put ideas into action. We did this through a mix of face to face discussions, online survey and written feedback. We targeted those who attended our deliberative event in November, our Thinking Partners Group and Patient and Public Involvement Reference Group, local voluntary and community groups (including Healthwatch and the Voluntary Sector Coordination Project), NHS staff and GPs. The discussion document was also discussed at the Voluntary Sector Forum, Healthwatch Assembly and St. George's Patient and Public Engagement Group and in addition Healthwatch Wandsworth ran a priorities survey, seeking comments to feed into the final plan.

Feedback received indicated that, overall there was a good understanding of the aims and focus areas within the plan. Whilst it was agreed the priorities within the Wandsworth plan were appropriate, it was noted that there are also priorities held at the South West London (SWL) system level (e.g. cancer, maternity and children). It was felt that these are equally relevant but are not fully reflected in the Wandsworth plan and this represents a challenge for some stakeholders and providers in how they can best engage across all the priorities at different levels.

What did people tell us?

Here is a summary of what people told us throughout our engagement process. Overall, people were supportive of a focus on prevention, community activation and self-management as well as greater involvement of the voluntary sector in providing solutions to health and social care challenges, with the right resources. It was recognised that none of this would be possible without a strong and stable workforce and increasing the use of technology. A strong theme throughout the feedback was around increased support and recognition for carers.

Start Well	
	Greater provision of emotional wellbeing services for children and support for parents – some services in the wider community are currently not easy to access with long waits.
	Some felt children and young people should be involved in the wider group and community rather than doing healthy activities in isolation.
	Support should be given to enable social gatherings, community building, activities, events and groups and it was suggested that services could help with financing and resourcing.
	Supporting healthy weights for children and incentivise healthy eating
	Involve young people and schools in conversations about risky behaviours – in particular, gang culture

Live Well

When asked about services considering physical and mental health and wellbeing at the same time and about health and social care services working together, the following points were raised.

Easy and quick access to services was highlighted as important by many

More community and peer led drops-in and multi-disciplinary teams

More advocate and buddy systems based in the community

Mental health and drug and alcohol services working together

Easy access to people with expertise to help, advise and provide information, including prevention and self-management to keep well

More access to information, support from dieticians and physical activity

An exploration of barriers to accessing self-management services

Tailoring information and support for different cultures and language users was highlighted as important

Community-based support groups, buddies and peer support (some already attended a community group that helped provide this support and felt it was very useful)

Age Well

Most of the feedback received related to communities building resilience and increased access to services. It was noted that most of the actions in the plan relate to specific health services and interventions and suggested the voluntary sector will bring community-based support alongside services. However, it was felt that specific community capacity and resource building isn't outlined in detail.

The following feedback was provided about the plan in relation to dementia, isolation and about health and social care services working better together.

The plan should include intergenerational projects with schools and young people to support in reducing social isolation

More support networks, buddy systems and community activities and information about the support available – support for financing and resourcing community activities

Advice and proactive access to services (rather than reactive)

More services and support for dementia, including lifestyle services that can help as well as cognitive rehabilitation

So what?

It's important for all partners involved in implementing the health and care plan to demonstrate how feedback from local people has shaped the final plan. Health and care partners have considered the themes from the feedback provided to inform the final version of the health and care plan. The following changes have been made to the plan in response to the feedback received:

You said	We did
Start Well	
Greater provision of emotional wellbeing services for children in schools and support for parents - services in the wider community are currently not easy to access with long waits.	Education wellbeing practitioners are now in place in some schools in Wandsworth and further teams will be rolled out in 2020.
Some felt children and young people should be involved in the wider group and community rather than doing healthy activities in isolation.	We have committed to work with leisure and environment partners to encourage more use of open spaces, playgrounds and sporting activities
Supporting healthy weights for children and incentivise healthy eating	Health Visiting Team and Children's Centres promoting healthy weaning and healthy diet. Family based weight management interventions appropriately focused towards early years and children in primary school
Involve young people and schools in conversations about risky behaviours – in particular, gang culture	This will be central to our approach as we develop our plans
Live Well	
Easy and quick access to mental health services was highlighted as important by many	We are investing in talking therapies to bring down waiting times
Mental health and drug and alcohol services working together	We are running wellbeing workshops within substance misuse services for people who are currently engaged in work around abstinence. Closer links between the mental health and drug and alcohol services means that we are now often able to see people for treatment whilst they are engaged in ongoing maintenance/ abstinence work which helps early intervention in mental health problems that may be a trigger alcohol/substance misuse.
Easy access to people with expertise to help, advise and provide information on diabetes, including prevention and self-management to keep well	We will provide extra capacity at evening and weekends for structured education programmes to improve uptake.
An exploration of barriers to accessing diabetes self-management services	We will carry out insight work in 2020 to understand what these barriers might be

You said	We did
Age Well	
The plan should include intergenerational projects with schools and young people to support in reducing social isolation	We have committed to working with the voluntary sector to develop activities to bring younger and older generations together
Advice and proactive access to services for older people	We will work to identify older people who are at risk and develop a person-centred plan for their care, bringing all organisations together
More services and support for dementia, including lifestyle services that can help as well as cognitive rehabilitation	The roll-out of face to face social prescribing services will help people access services within their communities.

Implementing our plan with the ongoing involvement of our local community

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. We know, from looking at the profile of people we've heard from during our engagement work, that we've reached a good cross section of the community. But, there's always more we can do. Our approach to ongoing engagement will be multi-facetted:

1. Direct engagement – involving people with lived experience of services directly in project working groups, where possible. Testing communications and engagement plans with existing channels, such as the CCGs Patient Engagement Group.
2. Wider engagement – working with existing voluntary and community groups to speak to those they work with.
3. Targeted engagement – working with those most impacted by specific projects within the plan and current service users. This might be through holding bespoke focus groups, surveys and telephone interviews.

Work is already underway to involve local people in several projects within this plan – see some examples of this below.

Area of the plan	How are we already involving local people in implementing the plan
Start Well	• Working with children in schools to seek feedback on the mental health support being provided – including selecting a provider for online counselling services and tailoring promotional materials so they are more young people friendly
Live Well	• Working with Healthwatch to interview mental health service users, to improve the pathway for those in crisis. • Improve the uptake of structured diabetes education by engaging targeted communities such as men and those from BAME communities to understand how courses could be tailored to better meet different needs
Age Well	• Running an integrated communications and engagement campaign around Dementia to focus on supporting dementia friendly communities and carers through awareness raising.

We are committed to making sure we share the outputs of our engagement work by feeding back directly to groups we've worked with; by publishing feedback reports online and using those involved as champions to spread the word about the impact their involvement has had. Keep an eye on our website for updates on our work.

Appendix 1
What we will do

- **Plan overview**

Start Well

Cross cutting issues
Children and Young Peoples mental health
Childhood obesity
Risky behaviours

Live Well

Integrating approaches to Physical and Mental Health
Chronic disease management - Diabetes

Age Well

Integrating Health & Social Care
Dementia
Social Isolation

Our Vision:

We want people to live and remain as healthy as they can, for as long as they can.

Our priorities go across the age spectrum focusing on prevention, supporting independence,

good health and wellbeing and enabling local communities to become more resilient

Responding to the needs of Wandsworth Residents		Focus on	Impact for Wandsworth residents
Start Well	**Rationale - the health divide is evident from childhood; what happens in childhood lays down the foundation for health and wellbeing throughout life**		
	Start Well Charter Commitment to ensuring good experiences for children looked after, children known to children's social care and children with special educational needs and disabilities (SEND) and complex needs Childhood Obesity • In Wandsworth 1 in 6 children are overweight when starting school and this grows to 1 in 3 when leaving school. Children's and Young People's Mental Health • An estimated 2,800 children aged 5-16 have mental health disorders in Wandsworth; half of lifetime mental disorder has arisen by the age of 14 and 75% by the mid-20s. Therefore, services to prevent mental disorder have greatest impact in pre-teenage years. Risky behaviours • It is estimated that 12% of 15-year-olds in Wandsworth partake in 3 or more risky behaviours	Childhood Obesity • The prevention and management of childhood obesity Children's and Young People's Mental Health • Improving resilience and emotional and mental wellbeing, and experience of and access to mental health services Risky behaviours • Protecting children from the impact of risky behaviours	• Improved patient experience • Improved access to services • Reduced stigma • Person centred services tailored to individual and family needs
Live Well	**Rationale -Good mental health is the foundation for living well**		
	Integrating Physical and Mental Health approaches • Increasing numbers of people aged between 16 and 74 have a common mental health disorder such as depression and anxiety • 22% of people attending A&E had mental health issues • 44% of adults in Wandsworth drinking more than the recommended limit of per week Chronic disease management - Diabetes • Increased diabetes prevalence • An estimated 9.0% of people in Wandsworth with nondiabetic hyperglycaemia who are at increased risk of developing diabetes	Integrating Physical and Mental Health approaches Chronic disease management - Diabetes • Developing a care model that underpins a holistic approach to self-management and focuses on prevention and health inequalities.	• Improved access, earlier diagnosis and improved recovery rates • Improved wellbeing and independence • Greater LTC control and outcomes • Improved access to services • Improved glycemic control and quality of life.
Age Well	**Rationale - healthy life expectancy is shorter than overall life expectancy and the average person can expect 15 years of deteriorating health**		
	Joined Up Health and Social Care More people are living into older age; the number of people aged 65 or over is projected to increase by 44% in the next 20 years. • The rate of hospital admissions for injuries due to falls in those aged 65 and over is significantly higher than the national and regional averages • Inequalities in life expectancy and healthy life expectancy Dementia • Increasing rates of diagnosis and awareness, which has system wide implications for both health and care Isolation • Isolation in older age is a preventable cause of physical and mental health problems. 39% of > 65s in Wandsworth live alone. Isolation in older age often disproportionately affects people living in more deprived areas or who are on low incomes	Health and Social Care Integration • Proactive and preventative services, rapid response, improving discharges, enhanced support to care homes and falls prevention Dementia Awareness and early diagnosis, integrating dementia care into other care planning streams Isolation Increasing adult and older people's access to community based activities	• Improved patient experience • Reduction in falls and ambulance callouts • Fewer emergency admissions and A&E

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Wandsworth's Start Well Charter

We all think family.

We listen to children and young people and give them opportunities to shape the way we work.

We work collaboratively.

We make accessing help and information easy for children, young people, families, communities and professionals.

We deliver and commission services in partnership with each other.

We promote healthy choices.

We invest in support for new familiesa and parents, from birth or before, support for children and young people through transitions and support for adolescents to become adults who thrive, even when this means we need to work beyond 19.

Start Well Cross-cutting issues / actions

What will we do	Description of initiative	What will be the impact	How will we measure success
Support the Health and Wellbeing role of Schools	Develop a long term strategy and programme to support health and wellbeing in schools. This would include a range of topic areas such as mental wellbeing, physical activity, healthy eating and substance misuse Encourage whole school approach across all schools in the borough	Ensure there is a clear strategic direction to ensure cumulative effect of different initiatives to improve overall health and wellbeing in schools Establish the evidence base and what priorities should be focused on which can help to strengthen the case for funding key initiatives or programmes Working with partners to ensure a collaborative strategic approach to support schools	The development and adoption of a clear strategy Public Health Outcome Framework indicators over longer term School surveys
Support schools in their delivery of mandatory RSE and HE	Working with partners to support schools in delivering relationships and sex education and health education (including mental and physical health education)	Implementation of RSE and HE from September 2020 across all schools	All schools meeting the 2019 regulations
Parenting Strategy, including universal and targeted parenting courses and programmes	Universal and targeted evidence based parenting programmes focussing on attachment security, behavioural self regulation and cognitive development Comms Strategy to enable parents to increase protective factors and reduce risk factors relating to mental disorder	Improved attachment, self-regulation and self-esteem Reductions in adverse childhood experiences and emotional psychological distress	Course evaluation, parent/child feedback

Start Well – Children and Young People's Mental Health - what we will do

Summary Description of the programme		What will be different about our approach	
We want more children and young people to access emotional well-being and mental health support at the right time and place		Promoting Resilience, Prevention and Early Intervention.Early intervention is associated with improved outcomes. Our ambition is for evidenced based interventions to be available to every child and young person as soon as they need it. From 2019 there will be more preventative work in schools, and by 2021 we hope all schools with have emotional resilience programmes and early help	
What will we do	**Description of initiative**	**What will be the impact**	**How will we measure success**
Youth Mental Health First Aid training for Schools, Colleges and Youth Services	Mental Health First Aid equips people to help individuals developing a mental health problem, experiencing a worsening of an existing mental health problem or in a mental health crisis. The training teaches people how to offer initial support until appropriate professional help is received or until the crisis resolves	• Improved access to services for young people experiencing psychological distress • 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, schools, colleges and universities
Whole school emotional resilience programme in primary schools	Universal Whole School Approach to develop social and emotional learning of children aged 5 - 11	• Improvements in self-esteem, self control, emotional intelligence, and conflict resolution • Reduction in emotional distress, aggressive behavior and conduct problems	Number of schools delivering PATHS Longitudinal assessment against baseline using Strengths and Difficulties Questionnaire
Social and Emotional Learning programmes for secondary Schools	Universal and targeted programmes to support adolescent mental health	Improvements in self-esteem, self control, emotional intelligence, and conflict resolution Reduction in emotional distress, aggressive behaviour and conduct problems	Number of schools delivering evidence-based programmes Longitudinal assessment against baseline using appropriate validated evaluation tool
Improving access and effective support	Map of CAMHS Services and interventions within the new Pathways documents for anxiety, low mood, depression, social & communication difficulties, self-harm, and behaviour. Work with Local Authority colleagues to jointly commission new programme of ASD pre and post diagnostic support for children and their families	Clear pathways, referral criteria and specifications which will deliver improved services To help young people know where to go when they need help.	Increases in service utilization Through co-production work and feedback from children and young people
BAME Mental Health through Community Pilot Project	A scheme to train young people to provider peer support around emotional/ mental health.	This will include a comprehensive creative and cultural curriculum, building young people's self-awareness and confidence	Feedback from children and young people

Start Well – Childhood Obesity - what we will do

Summary Description of the programme		What will be different about our approach	
Action to reduce childhood obesity as measured by the National Child Measurement programme		A whole child/young people/ think family approach will be taken. This will commence antenatally and will continue through early years services and into primary phase education, and also involve the wider community	
What will we do	**Description of initiative**	**What will be the impact**	**How will we measure success**
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	To expand the Daily Mile Programme and encourage schools to implement it. University of Stirling found that the Daily Mile makes primary school children more active, less sedentary and improves their fitness and body composition. Increase in physical activity for children and families	Number of schools and children who take part in the DM on a regular basis Participation in sports across borough Use of green space
Encourage healthy weight in early years	Universal support across maternity and early years services and wider community venues, to support mothers breastfeeding and healthy weaning Appropriately focus family based weight management interventions towards early years and children in primary school, post-natal women who are obese, children aged 2 years and children who have been identified as overweight or obese through the National Child Measurement Programme Work with Health Visiting Team and Children's Centres to promote and advise on benefits of breastfeeding to improve initiation and sustained rates. Work with Health Visiting Team, Children's Centres to promote, advise and model benefits of healthy weaning and healthy diet Work with the child's school and family, School Nursing and the Health Weigh Management Service post 1st NCMP measurement (reception) to develop a Heath and Wellbeing plan for the child and their family	Approximately one in five children are overweight or obese in reception but this rises to one in three by year 6. It is important to focus towards early help and prevention to reduce the number of children going on to become overweight or obese. Improved initiation and sustained rates of breastfeeding Higher proportion of children making health transition from breast to healthy solid food Reduction in weight/BMI at the end of each academic year	Reduction in BMI Increase in hours of physical activity Changes in family diet Change in self-efficacy measures Improved breastfeeding rates at 6-8 weeks Number of children receiving a health diet obtained through survey in CC
Build and create healthy environment	Work with planning and licensing to implement the 400m exclusion zone around s schools for new 'fast food' retailers. Explore changing license permits to only be valid for owners rather than the premise Work with partners to encourage healthy environments for children and their families	To manage environments around schools to encourage healthier choices and reduce the availability of unhealthy foods Encourage all environments to support healthier choices for parents and families	Number and concentration of unhealthy fast food retailers within 400m of schools Partners and organisations offering healthier choices

Start Well – Risky Behaviours - what we will do

Focus on prevention and early intervention initiatives and approaches to reduce the take up of risky behaviours

The focus of our approach will be:

- Identifying Young People involved or likely to be involved in risky behaviour
- Whole family support for those that are at risk
- Engagement with Youth
- Developing a multi-agency approach

Key initiatives in development:

Improving partnership working and strategic planning - Early Help, Community Safety and Schools Partnership to develop a consistent local strategy and response to knife crime and serious youth violence with schools.

Sharing and promoting good practice in relation to exclusions and managed moves – Working with schools partnership to review and update as necessary the local response to exclusion and managed moves.

Coordinating early help and prevention - Develop Early Help service offer and response to support inclusion of children at risk.

Improving information sharing – Working with school partnership to improve early identification and communication in relation to children at risk.

Teaching the curriculum and supporting children to achieve – Early Help services to collaborate with schools to support effective PSHE and awareness of key risks for children.

Preventing and tackling knife crime - Develop a multi-agency strategy to prevent and tackle knife crime, through taking a Public Health approach

Live Well - Integration of physical and mental health approaches – what we will do

Summary Description of the programme	What will be different about our approach
A person's mental and physical health are intrinsically linked but the life expectancy for people with Serious Mental Illness is 15 – 20 years lower than the general population. This disparity in health outcomes is partly due to physical health needs being overlooked but also partly due to the lack of emphasis given to mental health and wellbeing. The Programme of work outlined below intends to bring pro-active care closer to home to support people to manage both their physical and mental health with equal emphasis	There is a compelling case for delivering care in an integrated way to ensure that a person's mental and physical health needs are met together. Our approach to integrating services is based on feedback from both the general and clinical communities in response to gaps or areas of improvement identified. Our ambition is to improve accessibility and address health inequalities for the benefit of the overall population of Wandsworth

What will we do	Description of initiative	What will be the impact	How will we measure success
Physical Health Checks for people with Serious Mental Illness	Primary care teams (GP's) will be incentivised for carrying out 50% of the annual physical health assessments targets including follow-up care	• Patients with a diagnosis of severe mental illness will live longer • Fewer patients will attend A&E and GP surgeries with chronic physical health problems. • GPs will be able to maintain close contact with their higher-risk mental health patients • SMI patient will benefit from peer support which can assist them to access vital medical assessment appointments and to receive healthy living lifestyle support	to ensure that 60% of patients with SMI to have an annual health check (50% in primary care and 10% in secondary care)
Talking Therapies (IAPT)	In 2019-20 we will be increasing access to psychological support to 22% of the population estimated to have either anxiety and/or depression. Working alongside GP's and the mental health providers we will seek opportunities to provide access to clinical support in less formal settings including GP Practices	• Earlier diagnosis leading to higher recovery rates • Embedding the service within GP Practices and other informal settings will enable improve access from hard to reach groups such as men, and those from a BME background	Success will be measured against national standards i.e: • Access = 22% • Recovery Rates = 50% • Access to first treatment = 75% of referrals in < 6 weeks • Access to second treatment = 95% in <18weeks
IAPT Long Term Conditions Pathway	Around 40% of people with depression and anxiety disorders also have a long-term physical health condition. By providing support to people with diabetes, COPD and Cardiovascular conditions the evidence shows that we can reduce the number of unnecessary hospital admissions as a result of these conditions, maintain positive wellbeing and also support people to manage their conditions better within the community setting	• A multi disciplinary approach enhances whole team's capability to provide more comprehensive, accessible and holistic care to patients • Promotes mental health awareness and faster diagnosis identifying and addressing a person's needs more quickly and accurately can in turn reduce the number of frequent attenders and repeat assessments • Promotes coordination and encourages the development of a single jointly-developed care	Success will be measured against national standards i.e: • Access = 22% • Recovery Rates = 50% • Access to first treatment = 75% of referrals in < 6 weeks • Access to second treatment = 95% in <18weeks • A reduction in A&E attendances and inpatient admissions
CAHS Home Based Support	Following pilots commissioned in 2019-20, it is proposed that a mental health support worker is commissioned to work alongside Central London Community Health Trust to identify patients with Long Term Conditions that could benefit from support with mental health needs	• A multi disciplinary approach enhances whole team's capability to provide more comprehensive, accessible and holistic care to patients • Promotes mental health awareness and faster diagnosis identifying and addressing a person's needs more quickly and accurately can in turn reduce the number of frequent attenders and repeat assessments • Promotes coordination and encourages the development of a single jointly-developed care • Reduction in the number of unnecessary GP referrals and/or A&E Attendances	The measures of success are to be confirmed but could include measures such as: • Improved confidence to manage their wellbeing • Reduction in London Ambulance conveyances • Reduction in the number if unnecessary A&E attendances

Live Well - Chronic disease management – Diabetes -what we will do

Summary Description of the programme	What will be different about our approach
There is an increasing prevalence of diabetes in Wandsworth and the current service model will not be able to provide sufficient proactive and holistic support. The new model of care enhances the ability of primary care and community services to support patients outside of acute hospital settings, thus managing their disease more proactively and reducing the likelihood of complications.	The new service model will result in;: ¨• Prevention of Type 2 diabetes through increased screening and annual recall of patients at risk of developing diabetes • Early identification, improvement in treatment of and prevention of the complications of diabetes • Improved access through patients can access diabetes care closer to home, in the right place and at the right time. • Reduced attendances in acute settings as more patients will be supported in primary and community settings. • Improved patient experience and outcomes • Patients to be better supported to self manage • Improved sustainability and reduction in variation in quality of care for people living with diabetes • Upskilling of primary care workforce and enhanced collaborative working across all providers

What will we do	Description of initiative	What will be the impact	How will we measure success
New Model of Diabetes Care	The new diabetes service model will deliver the following: a) A Primary Care Local Incentive Scheme (LIS) which will support primary care to offer consistent care for diabetic and pre-diabetic patients b) Consultant deep-dives in primary care b) Additional clinical capacity in community settings to enable more patients to be supported closer to home	• Improved prevention and management approaches of patients at an earlier stage, with pre-diabetic registers established in all GP practices • Improved detection and diagnosis of non-diabetic hyper-glycemia and Type 2 diabetes • Reduced hospital admissions and lengths of stay	• Reduction in prevalence of Type 2 diabetes • Reduction in hospital admission and length of stay • Improvements in quality of life indicators/ patient experience and reduction in diabetes-related complications
National Diabetes Prevention Programme (NDPP)	A free education programme for those who are at risk of developing Type 2 diabetes or have Non-diabetic Hyperglycaemia. NDPP is a tailored, personalised support including education on healthy eating and lifestyle, help to lose weight and physical exercise programmes	• Reduction in the number of patients at risk of developing diabetes	• Increased notification of patients with NDH • Increase the number of patients accessing NDPP programme
Diabetes Book & Learn	An on-line booking service for patient diabetes education courses. The service accessible to both patients and GPs across south London for both Type 1&2 The Diabetes Book & Learn Service also holds a directory of lifestyle and community services including mental health services and patients may be signposted to services available in their own local areas	• Improve access and take up of diabetes structured education • Improve choice for patients • Standardise processes across south London which will reduce and streamline administration	• Increase in the number of referrals for diabetes structured via both GPs and self-referrals
Diabetes Structured Education	Diabetes Structured Education for patients with both Type 1 &2 Diabetes. The accredited structured education covers traditional education, on-line/digital education which is accessible via the Diabetes Book & Learn Hub, extra capacity during evenings & weekends and sessions targeting primarily BAME patients	• Increase in referrals and attendances at diabetes education courses • Improved glycemic control and quality of life	• Year in year increase in attendance at structured education courses and improvement in patient reported confidence to self-manage

Age Well - Health & Social Care Integration - what we will do

Summary Description of the programme	What will be different about our approach
To integrate (join up) health and social care services to provide a better service to residents	We currently have strong joint working across health and social care, including developing joint strategies and jointly commissioned services. We need to focus on the next stages of integration around the individuals' experience of care

What will we do	Description of initiative	What will be the impact	How will we measure success
Integrated intermediate care/reablement services	Integration of intermediate care and reablement pathways and services with a focus on: a) rapid response to avoid admissions to hospital b) home first principles to support more people to receive services in their own home	• Improved access into intermediate care 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 • Integrated services available in the community on a rapid response basis, with a re-provision of intermediate care beds to home based rehabilitation	• NEL Admissions • % people accessing reablement on discharge from hospital • LOS • "91 day" reablement target • Improved patient experience
Coordinated/ Integrated Complex Case Management	• To build on integration of community services for people with the most complex health and social care needs • This includes review of Enhanced Care Pathway specification and social care team in Community Adult Health Services	• More timely, coordinated access to health and social care services • Person centred and holistic assessments and interventions for individuals and their carers	• NEL admissions • Joint care plans (is this an area for development 20-21) • More patients enabled to access the MDT meetings throughout the year.
Falls Prevention	Enhanced community exercise programme with access to evidenced based training	• Better access to evidenced based falls services available in local areas • Specialist teams to provide training to a wider range of health and social care staff as preventing falls is everyone's business • A better integrated service across health and social care to assess those who are very frail	• NEL admissions • A and E attendances • Outpatient appointments • Improved patient satisfaction
Enhanced Support to Care Homes	More integrated health and social care for very frail, including residents in care homes Better access to care at home following a fall and access to falls prevention training and strategies to reduce the number of falls in the future	• Better care provided in care homes as better and quicker access to NHS care • Improved training provided on an ongoing basis to care home staff • Better communication between GPs, the hospitals and the care homes through the use of the Red bag and better proactive care planning • Regular MDT meetings to develop strong care planning in care homes led by the GPs and supported by a wider MDT team • Greater collaboration with the LA regarding quality improvements in homes	• NEL admissions • LOS in hospital • A and E attendances • Number of conveyances
Integrated Equipment	To build on integrated equipment offer, ensuring that the right equipment is provided at the right time (using trusted assessments across health and care as appropriate)	• More timely provision of services • Reduce duplication/transfers between health and social care organisations • More efficient provision of equipment services	• Recycling rates • Reduction in high delivery costs (improve equipment stores)

Age Well – Dementia - what we will do

Summary Description of the programme		What will be different about our approach	
Improved care planning and making services and information more accessible to dementia sufferers and their carers		Integrating dementia care into the care planning of other services	
What will we do	**Description of initiative**	**What will be the impact**	**How will we measure success**
Improve Care Navigation and planning, integrating dementia care into other care planning streams	Streamlined pathways of dementia services, with better interface between community services and specialist mental health 11 services	• Improved access to information • More people able to maintain independent living in their own home or place of care • Reduced number of NELs for people on GP dementia registers	Early diagnosis rates Fewer emergency admissions
Improve support to unpaid carers of people with dementia	Aligned pathways for unpaid carers for people having specialist mental health dementia services More proactive engagement with carers	• Improved access to information for unpaid carers • Improved support for unpaid carers	Improved satisfaction Carer support for people with Dementia Reduction in NELs A and E attendance and outpatient attendances

Age Well - Isolation - what we will do

Summary Description of the programme		What will be different about our approach	
Work with our partners to support and develop initiatives to combat isolation and its impact on both physical and mental health		Increased focus on preventative initiatives and Social Prescribing	
What will we do	**Description of initiative**	**What will be the impact**	**How will we measure success**
Commissioning of Voluntary sector preventative services	Reshaping of preventative services including: Commissioning of Age Well services in Battersea and Roehampton, with a focus on intergenerational activities Commissioning of enhanced Voluntary Sector Coordination programme community navigation service for individuals and their carers Enhancement of Better at Home service	• Reduction in social isolation • Healthier lifestyles for older residents • Increased opportunities for people to have support from and to make contributions in their community • More support to older people in their on homes • Creating a more coordinated, better connected third sector	Improved satisfaction Increased number of people accessing services
Social Prescribing	To support our digital Social Prescribing offer (the Wandsworth Wellbeing Hub), we will be aiming to launch our face to face Social Prescribing service in Wandsworth for service commencement by September 2019. This will allow 16 Practices across the 3 localities to deliver face to face social prescribing for their patients	• Reductions in secondary care usage • Further support for those with mental health, who are socially isolated and those who have a social determinant of health	Reduction in secondary care usage will be capture and reported by NEL CSU, which will then be measured against the Social Prescribing QIPP target. The Prescribers will continue to use the Wellbeing Star evaluation tool to monitor the health and wellbeing of patients of have accessed the service.